THE RADICAL THERAPIST 75¢

is changing its name to...

ROUGH TIMES

VOLUME 2 NO. 6 therapy is change...not adjustment APRIL, 1972

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ROUGH TIMES [illegible] is published by The Radical Therapist, Inc. Subscriptions: $6/yr in the US, Canada and Mexico; $10/yr abroad; $12/yr for all institutions, libraries, etc.

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More Changes

It is time to ask whom THE RADICAL THERAPIST has been serving and what goals it has for itself.

We have discussed what the journal should be called again and again. All of us are dissatisfied with the name RADICAL THERAPIST, but we cannot easily agree on a new name.

The term RADICAL today is an intellectual/middleclass word which has been co-opted by hip professionals. The term THERAPIST reflects a professional/middle-class image. When we review the past two years, people who call themselves "radical therapists" – ourselves included – have not effected significant political change.

A million or more people are studying psychology today. Three million are in therapy; another million live oppressed lives in mental hospitals. The effect of "therapy" – school and community programs, mass media advice, etc. – has reached every woman, man and child in the country. Yet RT has a subscription list of only a few thousand; it has not yet related to the needs or wishes of the people. Instead it has catered to professionals.

We have all agreed now that the primary audience for this magazine should be *oppressed people.* Professionals who can relate to issues of concern to working-class, minority group and poor people are welcome to continue reading the magazine. But it will not be addressed primarily to them.

Our main goal is to join forces with people fighting their oppression and to serve this struggle.

To reflect these changes, we are doing the following things:

(1) changing the title of RT to *Rough Times,* thus moving away from a professionalistic/middleclass therapy-model.

(2) changing the layout and appearance of the magazine.

(3) soliciting and publishing more articles on common mental health problems –alcoholism, drug addiction, problems of nuclear families – and on ways of counseling each other.

(4) using our resources and skills to help other movement groups.

(5) giving full coverage and support to the efforts to establish Mental Patient's Liberation Fronts throughout the country.

(6) continuing to expose and struggle against the mental health establishment which oppresses people.

(7) developing a socialist editorial policy.

(8) making RT more readable, with briefer articles, news stories, non-technical language.

RT has provided middleclass professionals with new ideas and some energy. It has also helped spark hopes of patients and others seeking revolutionary alternatives – hopes which, in the main, it has not supported. We feel that professionals lack the class position – and thus the class consciousness – needed to identify themselves with revolutionary work. For this reason, we feel the professional's task is to understand their own privilege more, and to ally themselves with oppressed people and their struggle, not with the ruling class. This means changing whom they serve.

RT has had an upside-down orientation. We will now focus on serving the people – sharing skills, demystifying therapy, lending our support to people's struggles, helping meet people's needs to control their minds and their lives. Let those therapists who can relate to this goal join us.

We realize this is the beginning of a series of moves which will totally change what RT has been. We feel this is correct. Each of us is immersed in a profound historical process, and the forces of revolution are world-wide. We must relate to this reality.

We would welcome responses and ideas from our readers. Comments in the past have been very helpful, and we would encourage further dialogue at this point.

The staff of RT

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A SPECIAL WOMEN'S ISSUE HAS BEEN TENTATIVELY SCHEDULED FOR LATE SUMMER

We need articles, poems and graphics based on personal experience with organizing, consciousness raising, and either end of therapy – or discussions of the problems within the women's movement (e.g. Gay/Straight, Feminist/Marxist, and class conflicts) or whatever else you think might be appropriate. Send materials by July 15 to:

ROUGH TIMES
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The Radical Therapist is free to mental patients, prisoners, and GI's. Bulk orders are available for distribution in mental hospitals, prisons , community mental health centers, and other institutions. Please write us if you are interested: P.O. Box 89, West Somerville, Mass. 02144.

NOTE ON OUR LAST ISSUE:

We forgot to mention the quote from Che was sent to us by Lee Baxandall, and we thank him for it. The Kesselman piece was translated by Phil Brown and worked on by Laurin Pensel, too. We forgot the address of BROTHER, a forum for men against sexism, which is 828 Coventry Road, Berkeley, California 94707.

Bobbi Selcer's name was printed as the author of "How Liberated are Liberated Children?", but that article is also co-authored by Irma R. Milton.

THANKS to Joe/Media – and the Media Notebook, Jessica Murray, LNS and Nancy Henley for graphics in this issue.

SOCIAL CHANGE AT HARROWDALE STATE HOSPITAL

ONE IMPRESSION

A staff member of a large state hospital in the northeast contacted the *RT* group to tell us about changes occurring at the hospital. The director of the hospital, who is sympathetic to increasing patient control, had circulated copies of the Mental Patients' Liberation Front's *Bill of Rights* to all residents and staff and asked for their comments. A group of patients formed a Patients' Rights Committee and decided to have a weekend project where outside visitors would come and live at the hospital. It was hoped that these visitors would help residents "focus attention on the way people live here," "make suggestions for desired changes," and help plan strategy for action. I decided to participate in the project because it seemed like an important movement at the hospital, but wondered how much we could help in just a few days.

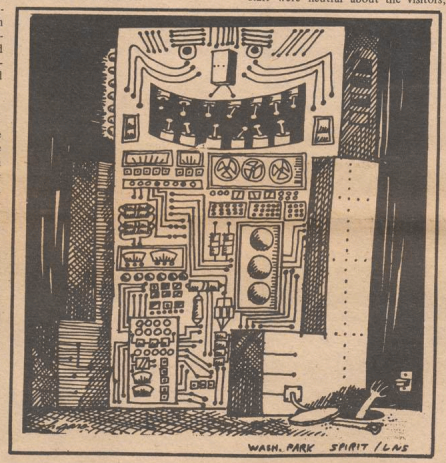
EXPERIENCES AT THE HOSPITAL

As is typical of state hospitals, the hospital is located at the edge of the city in an isolated area. The approach to the hospital grounds looks like the entrance to a wealthy mansion with woods leading up a hill to the administration building. As we entered the building someone called to us and I thought we were being stopped by security guards who would tell us we were trespassing. Fortunately it was two women from the patients' welcoming committee who accompanied us to the first meeting. As we walked through the administration building it occurred to me that these spacious elegant rooms would be a good setting for a voluntary therapeutic community. From this building we went back to the inner part of the "campus" and were immediately struck by the barren prison-like structures and repetitive design of walkways and buildings. The state hospital takes the worst aspects of city living and places them in a country setting.

The canteen was a friendly home-like place but almost empty on a Friday afternoon. There we met two girls from the adolescent unit who told us they were expecting me to stay with them for the weekend. One girl warned me that newcomers get hit around until they are accepted. Both girls talked openly about their situations, including the fact that the court sent them to the hospital. Two young women who were very active in the residents' group told us what had happened to them at the hospital. They both talked about how difficult it is when you leave the hospital to find a place to stay and to keep from being sent back. One woman said she had learned never to refer to the time she had been in a hospital, which left her with large unexplained parts of her life and made it impossible to feel a sense of continuity about herself. The other woman showed us one of her poems which was a beautiful expression of sadness. I was furious when she related that a friend outside the hospital told her the poem showed her to be schizophrenic.

As we walked further into the heart of the hospital complex, the buildings all looked the same and even with a map one could easily be lost. The presence of our resident guides provided an island of life and humanity in the midst of this overwhelmingly stark environment. There were very few people outdoors, but everyone we met was friendly.

The adolescent unit, where I was assigned to stay, is located in a sterile institutional building at the top of a hill near the edge of the grounds, adjacent to the farm. The door was locked and there was no sign of life from the outside. While waiting at the locked door, we began to experience the world where keys separate the "haves" from the "have-nots." We had no power to either get in or out and could understand why most of the residents expressed anger about the locked doors.



When I left the hospital grounds briefly on the evening of the second day, I was aware of being in the first stages of becoming institutionalized. The rich variety of an ordinary residential street in the outside world seemed almost too complex. It was a relief to be in an apartment with a refrigerator and a private bathroom, and a space small enough to feel at home in. The hospital is a combination of barren, unused spaced that cannot easily be made a part of one's personal space, and overcrowded areas such as day rooms.

THE ADOLESCENT UNIT

When we arrived at the unit, I told the teenagers that I would like to stay at their unit, but only if they wanted me to be a visitor. They said they knew someone was coming and were puzzled by my question. I was unable to make an agreement with them as the contract had already been made by the staff.

The unit director allowed me to come to their staff meeting. When I asked whether staff had been consulted about participating in the weekend project, the director told me that the decision was "voluntary" but there had been pressure to agree. I was disappointed that my coming to the unit reflected the lack of resident and staff participation in decisions in the hospital.

The adolescent staff were young, mostly women, a mixture of races, and all seemed involved with each teenage resident. The large staff/resident ratio and the many programs made it sound like a favored unit. According to the staff, most decisions are made by the adolescent staff and they have little contact with the rest of the hospital.

Staff reaction to the weekend project was mixed. Some were interested and wished that we were there on weekdays so that we could talk and see more of the unit activities. I too was sorry that we would not have more contact. Some staff were neutral about the visitors, stating that the project was too brief to have any impact. Others expressed negative feelings about the non-voluntary origin of the project and that they had only been given three days notice.

During the weekend, I spent a lot of time at the unit, eating meals there and stayed overnight the first day. The kids had been told I would "act like a patient" and was coming there to see what hospital life is like. I told them it would be hard for me to know what it felt like to be at the hospital as I knew I could leave. I was concerned about violating people's privacy by staying at the unit, but the kids seemed accustomed to having visitors. The teenage girl who agreed to let me share her room told me about her experiences in the hospital and life at the unit. She is a very perceptive person and aware of political issues in the hospital structure. I felt very close to her and enjoyed reading and discussing RT articles with her. She told me that people have to feel love toward one another to be alive and that was hard to find in the hospital. During the weekend she felt freer to say what she thought and became an active leader in the hospital liberation movement. Four of the teenagers came to the Sunday Town Meeting: none had attended since the previous summer.

Weekends are a bad time to visit because many of the kids have gone home and there are fewer staff and activities. Those who are left behind often dread the boredom of weekends, which become a round of meals, medication, TV and going outdoors. By the second day, I found the atmosphere made me feel bored, lonely and depressed. I saw how the residents might easily be irritated or start a fight to provide some activity.

Because many hospitals try to limit a person's stay to a few months, it was surprising to find that many teenagers had been at the unit for several years. The teenagers would be happier and function better outside the hospital environment in group homes, half-way houses, day programs. Even conservative mental health people advocate phasing out large institutions in favor of small community facilities. Small resident-controlled therapeutic living groups are needed for kids who are in conflict with their families. When I asked the staff why one teenager was at the hospital, they explained that she often didn't want to do the work activity and that she has "somatic complaints", both of which are common reactions in our society.

Most of the staff seemed interested in changing the adolescent unit. They described improvements made in the interior and plans for a total rearrangement of the space, making the environment more homelike and allowing more privacy for each teenager. Some staff agreed that it is important for the teenagers to say how they feel and take part in decisions on the unit. When the teenagers discussed the MPLF Bill of Rights they agreed with many of the rights but questioned how it could be applied at the unit.

COMMUNITY-WIDE EVENTS

The first evening at the hospital, visitors from RT and MPLF met with members of the residents committee and some staff to talk about experiences in the hospital. People were eager to talk with others in the hospital community and did not want to spend time planning a strategy for the weekend. I had wanted the residents to give us more guide-lines about ways of approaching different parts of the hospital community.

The first activity we attended was a hospital-wide dance for residents who were allowed to come (the adolescent unit was not included!). Most people sat quietly and watched the few people dance, with very little socializing. Several people seemed interested in the project and said they would come to the Town Meeting on Sunday. An older woman told me about how she no longer had visitors after having been at the hospital for several years. Some men also talked sadly about being at the hospital and seemed to have little hope of leaving. It seemed that the dance was one of the rare large social events, but no one was encouraging people to get together. While a few visitors talked with residents, many tended to talk with each other, perhaps because they did not know how to approach the silent on-lookers at the dance. I found most of the people to be friendly and interested in talking. When I was unable to understand what a person was saying, a friend from their unit would explain and thus help us to make contact.

Reminders of being in an institution were numerous at the dance, including purchasing tickets instead of money for snacks and seeing the staff herd people back to their units at the end of the evening. It is hard for residents from different units to assemble, but we managed to find a ward where the staff let us meet. This turned out to be a pleasant setting for a relaxed exchange of experiences between some visitors and residents.

Saturday afternoon several people from Number Nine joined us. The patients' rights group and visitors assembled at the Canteen in an animated and friendly way that made it seem like a swinging neighborhood pizza place. Distressed because she wanted quiet order, the patient employee who managed the canteen complained to a staff member about our behavior. Finally, she called the security force to have us removed, stating that we were driving others away. A forceful woman resident leader decided it would be best for us to leave without a confrontation. As we left there was a sense of excitement and being together that might have produced a sit-in had our numbers been larger.

Since we had been evicted from the canteen, all other meetings were held in the board room of the administration building. The formal structure of this room with its enormous table and high-backed chairs felt like upperclass society, which was a distinct contrast to the meetings that occurred. Several meetings were held on Saturday and Sunday in preparation for the Town Meeting. These sessions were open to any residents, staff and visitors who wished to join. New people came at each meeting, and many residents were able to express their feelings about the hospital for the first time to a sympathetic group. Once people were convinced that they had been heard they were freer to work on the tasks. A young man who took a leadership role early in these meetings became more articulate and political. A young woman who had been very active prior to the weekend was unable to put forth as much energy because of being involved with plans to leave the hospital the following week. The meetings resembled other movement groups and were a combination of consciousness-raising and planning.

During these meetings, visitors often acted as facilitators and consultants to the residents. Some visitors came on very strong as if they knew exactly what needed to be done. They were organizing people rather than listening to what was being said and offering suggestions. No matter how good a strategy is proposed, if it is offered by an outside expert (even a movement one) it can keep people from the process of gaining control – and even if acted upon would probably fail after a brief period because it does not reflect people's needs.

The MPLF visitors were especially helpful because they could relate what was happening to their own personal experience of hospitals. A local lawyer and some people from the nearby university were present to offer technical assistance and would continue to be involved after the rest of us had left. Most of the outside visitors were not essential for this weekend project. The advocate function of visitors could have been filled by local people who would be able to be more available to residents.

What had seemed like a hodge-podge at the last planning meeting emerged as a well-integrated program for the Sunday Town Meeting. About 150 people out of a population of 1200 residents assembled at the open two-hour meeting. This was considerably larger than the usual attendance at town meetings all of which are planned and directed by the residents. Presentations were made by residents, staff and visitors about what was wrong with the hospital and how it should change. This was followed by a lively response from the audience. A videotape was made of the meeting which may be used at units so that all residents of the hospital may hear about what is happening.

During the weekend, leaders of the resident movement became more vocal and energetic. A man who had been very scared of people on the first day became relaxed and active by Sunday. A teenage boy who was initially angry and cynical became excited and involved with the group. An older woman who was reticent spoke eloquently at the large town meeting. It seemed like we were building a new community within the hospital. As we worked together we all felt saner – to struggle for liberation is the best route to mental health.

THE NEED FOR CHANGE

There are many questions concerning the possibility of transforming a large state hospital into a therapeutic/liberating environment. This will not be possible unless residents can be involved in determining what their needs are and what programs are of help to them. Staff must also be involved in the process of change as they are in a critical position in regard to carrying out new projects requested by residents or mandated from the administration. If the staff have not been involved, they may disagree with the changes, feel uncertain about their job and in the end make things worse for the residents and themselves. Intensive small group experiences away from individual units might result in staff being able to connect some of their own life experiences of oppression with what people experience in a hospital. Staff must be given support and opportunities for new experiences to enable them to become part of a collective decision-making system with the residents.

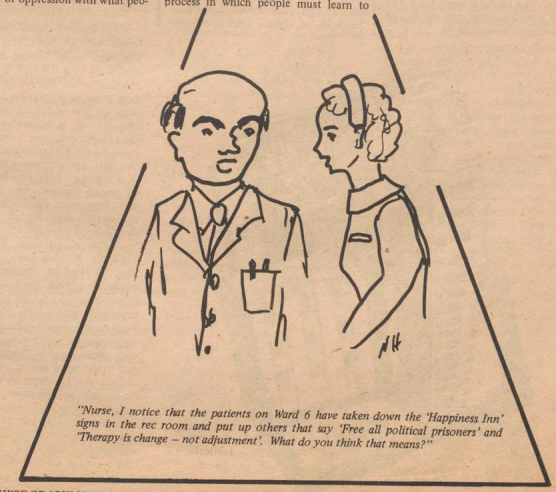
Residents in a mental hospital are handicapped in a liberation struggle by having to fight the label "crazy" and the social expectation that they are not able to take care of themselves and act responsibly. By reinforcing this label, the hospital keeps people feeling helpless and powerless. When patients behave in a way that someone dislikes or doesn't understand, their behavior is liable to be called crazy, which makes the person question what they are doing.

The hospital community is similar to many communities where people come together around what they dislike rather than shared positive goals. Since living in groups at a hospital is non-voluntary, people experience the bad aspects of group life – lack of privacy, no individuality, control by others. People do not need private property to feel human, but group living, even when voluntary, is hard for people in this society. A change to collective living in any setting must involve the participants' having control over the process. It is a long gradual process in which people must learn to work together, become active participants in the group, be able to be honest with each other and develop a group life which is responsive to individuals' needs.

While it is important to change hospitals, the long-range goal should be that no one would ever have to spend time in a large state hospital. This task involves changing society so that all people's needs can be met with the result that fewer people will be upset by the oppression they experience in their lifetime. This requires a total transformation of our social institutions such as the family, work and schools. It is the responsibility of each community to make room for people who need a place to get themselves together and for all of us to work for social change including developing helping networks among people. In the meantime we must support liberation movements such as the one which exists at the state hospital described here. We must continue to offer support to the resident movement along with other advocates within and outside the hospital.

Cynthia

"The Patients' Committee has determined that, under the Revised Token Economy, aides will receive 10 tokens for every helpful service performed; nurses will get 5; and shrinks get a token for each hour they stay away from us."



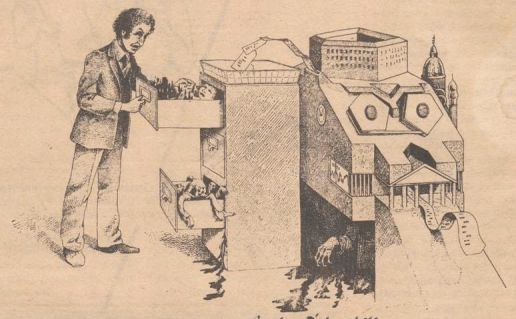
"Nurse, I notice that the patients on Ward 6 have taken down the 'Happiness Inn' signs in the rec room and put up others that say 'Free all political prisoners' and 'Therapy is change – not adjustment'. What do you think that means?"

** THESE GRAPHICS REFLECT THE THOUGHTS OF THE RT AND NOT THOSE OF THE PEOPLE AT HARROWDALE*

SOCIAL CHANGE AT HARROWDALE STATE HOSPITAL

ANOTHER IMPRESSION

Harrowdale State Hospital is a center of many contradictions. The possibilities of freedom run side by side with traditional authority; initiative and creativity co-exist with drab routine; patients' organizing and staff organizing occur together – sometimes complementary, sometimes contradictory. The weekend visitors found a situation which in many cases was that of a typical state institution, but which was in some instances atypical. Before presenting specifics, I will make several comments on the general nature of mental hospitals.



THE TOTAL INSTITUTION

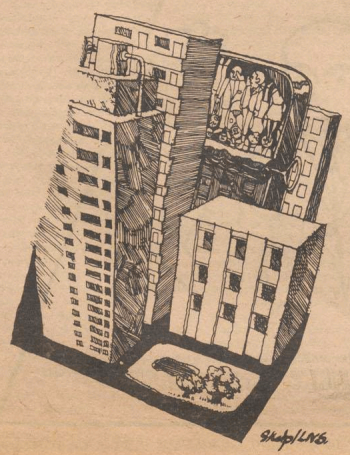
Regardless of specific and beneficial changes at HSH, it is still a total institution. The concept of a total institution, from Erving Goffman's *Asylums* and from our own experience, is a concept of an institution which has near-total control over the lives of the people in it. This can be due mainly to the institution itself, or to the institution and staff. Sleeping, waking, eating, washing, work, therapy (where existing), admission and release, visitors, privileges are all governed by rules and regulations. These rules may be waived at times, or overlooked; they can also be circumvented by patients. Admission and release are the least likely, however, to be overlooked or circumvented.

The participants in the total institution, particularly the residents, evolve a social order within the institution. This social order has two facets. On the one hand, it mirrors the outside society's views of appropriate belief and behavior. Thus, hard work, faith in one's "superiors," and rule following are all found in the total institution. The state hospital adds the class nature to the problem: most residents are from the working class. This means that they have the added oppression of class oppression. Also, this tells us something about the class origins of classification and "treatment" of "mental illness." What is called 'eccentric' among the rich is often called mental illness among the poor. To make it in the outside world of Amerika, a patient must make it in the inside world of the mental hospital: he or she is being trained to accept a certain class role (as well as sexual roles of various sorts).

The second aspect is that the inside society of the hospital is a special one. Based on a scarcity model (food, cigarettes, help, friendship, ground privileges are kept scarce, to be used as rewards), the social order is full of complex patterns of acquiring and bartering. People's lives revolve around the scarcity of survival- and human-needs. Although certain wards differ from others, the scarcity of things defines a different social order than exists on the outside. Residents choose certain jobs because of the things they can gain, rather than for intrinsic interest in the job. Freedom may be one motivation for job choice; so can the possibility of acquiring certain objects define that choice. If each ward or unit is a separate community, interaction between them is less easy than in the outside world – the restrictions of the administration and staff are the main defining and constricting elements on the inside.

The scarcity model is a widely-used model inside and outside. Capitalism utilizes this model in that its social order prevents the equal distribution of enough necessities and "luxuries." Thus, even though there is enough, the holding back of objects (and privileges) causes a certain dependence on the part of the lower rungs. In the mental hospital the residents are the lower rung.

Social orders can be constructed to cause certain overall behavior patterns Before Pinel and the French Revolution removed the chains of the asylum residents, their behavior was typically classified as manic. By the advent of the 20th century drug 'revolution,'patients' behavior began to be typically described as depressed or withdrawn. Regardless of the variety of classification today, "cooling out" is the primary overall method of making those classifications become reality. The setting up of a scarcity economy in the mental hospital causes atomized existences. The setting up of a post-scarcity social order would lead to honest social interaction and revolutionary change. The former set-up can be produced by the administration and staff. The latter set-up can only be produced by the residents themselves, although administration and staff can have a certain subsidiary role.



WHO ORGANIZED FIRST, RESIDENTS OR STAFF OR ADMINISTRATION?

It is my impression that the first moves towards liberalizing the HSH structures came through the enlightened work of a few staff members and administrators. The decision to have such non- or anti-professional "consultants" (like ourselves) obviously was indicative of a progressive approach. The enlightened and progressive elements of the staff/administration have seen that typical systems changes have been failures. They have been failures for several reasons. My view is that they have been failures not because they weren't clever enough, but because they didn't involve *liberation*.

Those of us from *The Radical Therapist*, Number Nine, Mental Patients' Liberation Project, and elsewhere have been involved in radical political activities which have centered around the various fields of psychology. We oppose the total institution because we understand the reasons why people were committed to mental hospitals. As I would put it simply, certain people had certain problems in living which came from an oppressive society, not from 'intra-psychic' problems. Social relations in our society take away the human social interaction that people are capable of. The family has played a major role as an institution which enforces social values and places stigmas on rebellious people. I will not go further into this, as the literature is widely available (*The Radical Therapist* partially defines its existence by these common assumptions). But I do feel that the analogy can be made from outside to inside, as a whole as well as in parts.

The civil rights movement failed because whites could not grant freedom to blacks. Blacks had to take their own freedom. Likewise, staff/administration cannot grant freedom to residents. They can, however, aid residents and themselves by cooperating with patients' liberation movements. They can also help by consciousness-raising and self-criticism among themselves – by investigating their assumptions about mental health and mental illness and their own position as mediators of the definitions of health and illness.

This formulation has certain implications. Foremost, I fear that even though staff/administration approaches may be progressive and good, they contain the possibilities of swallowing up the patients' rights movement. A second fear is that the state itself will crack down on all liberating elements. To counter the possibility of the residents' movement being swallowed up, and of the state's cracking down, I feel that certain paths must be taken. This includes the self-criticism by staff/administration as mentioned above. It also includes the strong solidarity of residents that can only come from wide-scale organization and relentless pursuing of all conceivable demands – including the eventual abolition of mental hospitals. While the visitors should return to HSH to continue their (hopefully) helpful roles, the resident activists could also visit the 'outsiders' to see what they are doing and how they can play a role in changing society and its institutions.

RESIDENTS AND THE MOVEMENT FOR CHANGE

The most articulate resident activists were between the ages of 16 and 25. This is similar to the radical movement on the outside, since people of this age group are the most sensitive to their oppression. Still living with their families, or only recently departed from the family situation, they are well aware of the dead-ends from family and school. They are also aware of the dead-ends in the mainstream society in which they can only get jobs (if available) which sap their creativity and humanity rather than expanding their possibilities. The large number of women involved in the residents' movement bears testimony to the added oppression of women in society (both hospital and outside).

The resident activists at HSH are basically new to activism. They have started at a gut level, a level of directly being in touch with their oppression. Their stories of family and school are vivid and recent. Likewise their accounting of incidents in the hospital. They are articulate to the point of being nearly totally in touch with their feelings and with what must be changed. Of course, the first amazement I felt was of their still being in the hospital. A few of them were, in fact, scheduled to be released quite soon. My conversations with a number of the patients' liberation activists were on a level of shared common assumptions about many facets of society. They made it clear to me what was going on in the hospital and the kinds of changes they envisioned.

At the several meetings, the residents spoke out against the large-scale use of drugs, the arbitrary actions of certain staff, the lack of wide-scale therapy programs, the delays in release (which they felt were wrong, since release involved holding a job, and often family consent, as well as a 'parole' status). They were angry about the difficulty many staff members presented them in terms of communication. This involved mail and phone privileges, as well as difficulties in attending patients' rights meetings. Many residents wanted the full use of an adjoining cottage not currently in use. It would be the center of their activities in the patients' liberation movement, and under their own control.

The activists should have the immediate use of that cottage, as well as private phone and office supplies for use there. Resident demands for lawyers (not state-hired), and for the development of outside communities could be realized by residents' use of the cottage. Many also expressed the desire to live there, and make it available for others, and would work to remove the fire hazards in order that it could be lived in.

Resident activists' demands for restriction of unlimited drug 'therapy' fall in the domain of existing state law, as do many other of their demands. Thus, activist demands for lawyers and ombudsmen could have the immediate effect of rightful enforcement of existing law. Demands for art, music, therapy, and work/education programs could also take place under the umbrella of the cottage.

As is the case with any liberation movement, those involved are quite capable of developing and carrying out their own programs. All they need in most cases is availability of resources, both material resources and resource people. I will deal with outside 'therapeutic communities' in a separate section.

STAFF

I found a greater number of enlightened staff personnel at HSH than I expected. This was mostly on the psychiatric staff level. These staff members were genuinely interested in the welfare of the residents, and in many cases were acting to realize that concern. Of course, staff concern is frequently paternalistic, but many HSH people were honestly concerned in a helpful and non-paternalistic way. Some aides expressed their work as 'therapists' in that they worked closely with residents to work through certain problems. These staff members were open about their capacity to be helpers, rather than custodians. They felt that higher staff (psychologists, psychiatrists, and nurses) spent little time with residents, were basically uninterested, and were resentful of lower staff for their crossing of traditional lines. Some staff members at the aide level expressed the desire to have seminars and courses with 'therapists' in order to gain from others' experience and to be able to provide more help to the residents. One young aide was particularly distressed that she could not attend a nearby drug seminar. The seminar was restricted to registered nurses and above, and this aide felt she could learn a lot about helping residents with heroin addiction problems if she were allowed to attend.

Aide response to patients' rights demands were conflicting. Many were open to it, seeing similar demands of their own which would make HSH a more liveable place. Others, however, were resentful, feeling that they were being neglected while residents were being pampered. A particular fear was of resident violence against staff. I would not deny all staff fear, but much of it is in fact conditioned by false stereotypes of residents. What is needed to alter this fear is a greater amount of seminar and similar situations in which staff (especially aides) can expand their knowledge and experience. Mental hospitals can only change if the barriers between professionals and lower staff are broken down, and everyone sees a commonality of interest, both as workers and as helpers of residents.

The number of units with non-psychiatrists as unit heads was an important point. This is part of the breakdown in professionalism, particularly in the one case where a social worker was unit head. Of course, breakdown of roles in such touchy areas can lead to resentment by upper-level staff, and only the tight community of aides and residents can combat the greater power of the higher staff. Conflict may also arise within the union structures (there are indications that it has already begun) over the breakdown of traditional job categories. Some union members will fear the loss of their jobs through such deprofessionalism. Others will understand that human interest in the hospital can only be served through the interchange of tasks.

RESIDENT–STAFF INTERACTION

As mentioned above briefly, there is a greater than usual amount of good interaction. Residents have understood that certain staff were trustworthy. Certain staff have come to understand the correctness of the patients' rights movement. Even among those residents not involved in the movement, honest attempts by the staff have been well received. Only through education programs for staff, and through resident activists' progress, will the interaction reach a relatively high and important level. Resident-staff interaction is not a separate category, but rather a synthesis of residents' and staff's growth.

ADMINISTRATION

A number of administrators expressed an honest desire to work for patients' rights and staff growth. These are the administrators who were behind the initial impetus for change, including the formulation of the visitor project. Through their own self-critical activity, and through their receptiveness to the residents' and staff's demands, these administrators can play an important role. Their honest concern for real change must be recognized,but it should be reiterated that they cannot be the sole agents of change. While able to alter institutional oppression to some extent, they will inevitably be in some conflict with residents and staff (this has already begun to a small extent). Residents who want immediate and thoroughgoing change will see these administrators as holding them back. Staff who fear change will see them as wild-eyed radicals. Further, the state will step in to investigate once things get going.

OUTSIDE THERAPEUTIC COMMUNITIES

Many resident activists felt that outside therapeutic communities were very important. They felt that the outside world was a series of traps in which one has to hold a straight job and adjust to society in order not to be re-committed. Hospital-promoted halfway houses do not meet the needs of residents, since such institutions are controlled by the hospital and remain attached to it. Residents should be able to form their own communities, with the aid of resource people from radical mental health groups and counter-institutional groups. Through participation in radical therapeutic communities , people would be able to live in an honest social setting and provide a place for others to stay when they are threatened with emotional problems.

In addition to providing self-help to the participants, these communities would be able to begin to put into practice the radical proposal of keeping people out of mental hospitals. Some of us among the visitors have wanted to be able to work with such counter-institutions, and would be likely resource people.

COLLEGE STUDENTS AND THEIR ROLE

If it could be worked out, wide-scale programs should be developed with nearby colleges to allow students to work at the hospital. For this they would be paid, and would receive full credit while being excused from regular requirements. Supervision would be primarily by the patients' liberation group, and secondarily by staff and administration. Some of these students might be able to help in the establishment of counter-institutions, as well as helping to break down the phony stereotypes of mental patients taught by the colleges. The training these students would get from such a program would be useful in destroying the traditional educational models for mental health and social welfare workers.

AN OVERVIEW

For myself, and for others of the visitors, the weekend at HSH was extremely important. It gave us a chance to see the beginnings of an important movement, and for us to help out in small ways. We met exciting people, who taught us more than we had to give them. We met staff and administrators who were open to real change, and were accepting of us and our ideas. We were more integrated into the hospital in a short time than I would have expected. I am remaining in contact with people at HSH, and we at *The Radical Therapist* will be sending bulk orders of the magazine to the patients to distribute as they see fit. We also expect to return when invited.

My weekend at HSH gave me an impression greatly different from other state hospitals, and more of a hope for radical organizing and change. The patients' liberation group can count on our support for their activities in whatever way we can be of help.

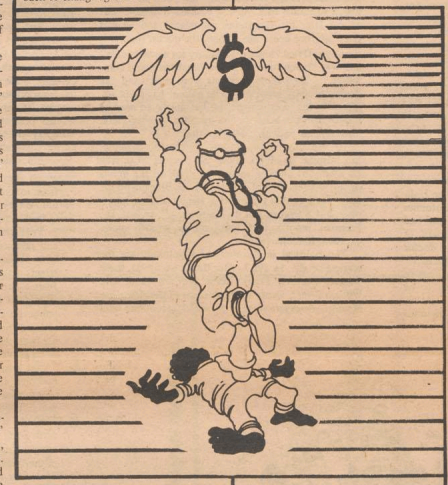
My one fear, as mentioned earlier, is of the movement being swallowed up. Tied to this is my feeling that the huge influx of visitors might have caused an unlimited optimism on many people's parts. Those of us who visited, and will return, can only act as catalysts and resource people, not as organizers. The real work will have to continue on the level of local projects, within the hospital community. I feel an incredibly large and beautiful energy at work at HSH, and am confident that many of the residents will be able to put that energy to work for themselves.

Phil Brown

WHITE

by Crystal Dawn Saylor

Wearing my white dress and white shoes
i walk down the white sidewalk to a white
church where all the white people go to
make their soul white and leave behind
their black sin And next week they'll be
back to change again from black to white



LOBOTOMIES ARE BACK

VIOLENCE ON THE BRAIN: USE OF LOBOTOMIES IN U.S. ON RISE

NEW YORK [LNS] – "While capital punishment is progressively being banished in civilized lands, many of these same nations are witnessing a resurgence of what can properly be described as partial murder of the mind," wrote Dr. Peter R. Breggin, a Washington psychiatrist at the beginning of March in the Washington Post. Breggin has recently done much to try to expose the increasingly frequent use of lobotomies or brain surgery to control such varied people as "overactive" children, addicts, depressed housewives, prisoners, homosexuals, alcoholics and old people.

Breggin defines a lobotomy as "a deadening operation that involves deliberate, irreversible damaging of an individual's brain for the purpose of altering behavior that others have deemed undesirable." –To make "violent" people docile. A lobotomy is a cutting of part of the front section of the brain which controls such human functions as insight, foresight, creativity, sensitivity, imagination, sense of self, emotional responsiveness, and abstract reasoning. A pro-lobotomy study said, "The patients [after lobotomy] tend intellectually to be more empty, with restricted interests and simpler satisfactions." Another researcher found "the disappearance of dreams as well as day dreams."

Since 1938 when the technique was developed, 50,000 lobotomies have been performed in the United States. In the mid-fifties the use of lobotomies seemed to taper off, mainly because their role had been replaced by increasing use of a variety of chemical tranquilizers. Walter Freeman, a doctor who Breggin calls the "dean of the lobotomists," said in 1965 that he felt that his early methods of big cuts in the brain "were too damaging to be employed in any but the most chronically and severely disturbed patients." But he listed new methods

of destroying brain tissue including the injection of liquid butane or "the patients own blood," ultra sonic beams, electricity to produce tissue searing heat, implanted electrodes through which current is sent until the surgeon hears "bubbles of steam escaping," gold needles left in place "for several months while weak currents were passed at intervals," radioactive seed implantations, beams from a 185-million volt cyclotron, and traditional cutting, with finer, more precise tools.

Currently over 600 lobotomies are performed a year in the U.S. (The technique is practiced all over the world – there was an international conference in Denmark in 1970.) In the U.S, they are performed on indigent patients – those in mental hospitals or other institutions who often can't or don't resist "consenting" to the operation.

Lobotomies have been performed on children as young as 4 years old (by Freeman, working with another doctor).

At a conference at the beginning of March in Houston on "Neural Bases of Violence and Aggression," attended by doctors from all over the world, a Dr. Sano from Tokyo was pleased to report that one of his best cases was a child who "became markedly calm, passive, and tractable, showing decreased spontaneity."

Another pair of doctors, Orlando J. Andy and Marion F. Jurko of the University of Mississippi, perform lobotomies mainly on institutionalized children who had "tremors, twitches and abnormal body movements, were explosive and impulsive." One nine year-old had holes drilled through his skull and electrodes passed deeply into the brain. He had another operation nine months later and he was allowed to return to a "special education school," but a year later his symptoms reappeared and he was given another operation. Then, the doctor reported, the boy suffered "impaired memory for recent events" and was "much more irritable, negativistic and combative." Two more incisions were made and the doctor proudly reported, "The patient has again adjusted to his environment and has displayed marked improvement in behavior and memory. Intellectually, however, the patient is deteriorating."

At the Kinsington, Ontario Psychiatric Hospital, the hospital wouldn't allow the doctors to operate on men, but allowed them to operate on the brains of 17 women instead. After all, as Breggin points out, "Men couldn't support a family after a lobotomy, but a woman can do housework." In fact, Dr. Freeman reports that lobotomized women make excellent housekeepers.

The political implications of lobotomies are the scariest of all. In 1967, after the Detroit riots, three Boston doctors, Frank Ervin, Vernon Mark and William Sweet, wrote in the *Journal of the American Medical Association* that if social, economic and

everyone in the ghetto would have been involved. They said that only a small portion committed "violent acts." They went on to suggest a preventative screening program to detect "brain disease" and to institute preventative treatment for potential rioters.

Mark and Ervin co-authored a book called *Violence and the Brain* in which they propose the development of an "early warning system" which would detect persons who could be expected to exceed "acceptable violence." Acceptable violence is defined as "the controlled minimum necessary action to prevent personal physical injury or wanton destruction of property." "The definition," the authors reassure us, "would apply equally to police or public authorities as well as to politically activist groups (students, racial, etc.) and all violent acts that did not fit into this category would be "unacceptable." Those that broke the rules would be treated by some violence-inhibiting method like brain surgery.

Ervin, Mark and Sweet are all associated with a newly-founded organization called the Neuro Research Foundation of Boston which receives grants from the National Institute of Mental Health (NIMH) and from the Justice Department's Law Enforcement Assistance Administration (LEAA), together totalling at least $600,000. LEAA is the agency that funds local police departments and helps equip them with riot control equipment. Included in the Neuro Research Foundation's grants is a $108,931 grant from LEAA to study "the incidence of violent disorders in a state penitentiary for men; estimate their prevalence in a non-incarcerated population; and improve, develop and test the usefulness of electrophysiological and neurophysiological techniques for the detections of such disorders in routine examinations."

Perhaps the best known place where some of these techniques are actually being used is the California Medical Facility at Vacaville. In December, some of the facts about Vacaville started coming out. At that time, state officials called a meeting to gain support from doctors for the expansion of Vacaville to house the 700 prisoners in the state's adjustment centers. The prisoners in the Adjustment Centers are, practically without exception, radicals – the "incorrigibles" of the state prison system. Under this plan, they would undergo a four-month treatment period during which they would be subject to treatments ranging from long-term tranquilization to shock treatment to lobotomies and other things very vaguely described as "aversion therapy."

Furthermore, about this time, someone ripped off and released a letter written by Director of Corrections R.K. Procunier, requesting a $48,000 safe streets grant from the California Council on Criminal Justice for a program of "Neurosurgical Treatment of Violent Inmates." [elsewhere this issue] After a public outcry the Director of Research at Vacaville claimed the plan for brain surgery and electric shock has been shelved and anyway the plan was only in the discussion stages.

But prisoners know better. Already a *Washington Post* reporter discovered that three prisoners had lobotomies performed on them at Vacaville in February, 1968. The doctor who performed the surgery admitted it and denied that lobotomies as a means of controlling violent behavior are only at an experimental stage. Said Martin Overton, who at the time of the three lobotomies was a neurosurgeon at nearby Travis Air Force Base, "I don't think this is an experiment at all. It's a tried method of doing a procedure. There are a number of people in the prison system who are there for life simply because they have uncontrolled psychomotor seizures. I think it's very benevolent to offer it to prisoners."

The reporter tracked down one of the prisoners who had a lobotomy. He complained of memory blackouts lasting as long as four days, headaches in the area of his right eye, numbness and loss of feeling in his limbs.

On Feb. 16 the newly-expanded Vacaville Center opened. They had added a new wing of 84 single-occupancy cells, all designed by Brown and Root of Texas and Morrison-Knudson of Idaho – the same companies that designed the infamous Tiger Cages in Con Son, South Vietnam.

Prison officials claim that the newly-expanded facilities are there to treat "volunteers" only. The question is what does "volunteer" mean in prison – especially in the California prison system where so many people have indeterminate sentences for which there is no end date. The parole board decides every year if they are going to get out.

One prisoner, Stoneleigh Singleton, was told if he signed the consent form he'd get more privileges, that by signing the consent form he wouldn't be considered a militant anymore. He has been in segregation for three years because he was labelled a militant and accused of assaulting a guard. So, he thought if he wasn't labelled a militant anymore he would be all right. His family realized what he was getting into and with some support from the community they got his transfer squashed.

Alfred Dunn, one of the Soledad Seven, who were charged in 1970 with assaulting a guard (charges were later dropped), was told after he refused to "voluntarily" transfer, that "he was going to rot" where he was. He and at least a dozen others have admitted to refusing to be transferred to Vacaville.

John Irwin, a former prisoner who is now a professor of penology at San Francisco State College, commented: "The Department of Correction now has been searching desperately for a new technique of control...Now they're concocting a new category: the revolutionary psychopath, aggressive personality, violence prone."

LOBOTOMIES and PRISON REVOLTS

Letter reprinted in LNS 3/18/72

State of California–Human Relations Agency
Department of Corrections
Sacramento, California

September 8, 1971

Mr. Robert L. Lawson
Executive Officer, California
Council on Criminal Justice
1108 – 14th Street, Room 500
Sacramento, CA 95814

Subject: Letter of Intent – Proposal for the Neurosurgical Treatment of Violent Inmates.

Dear Mr. Lawson:

The problem of treating the aggressive, destructive inmate has long been a problem in all correctional systems. During recent years this problem has become particularly acute in the California Department of Corrections institutions. To date, no satisfactory method of treatment of these individuals has been developed.

This letter of intent is to alert you to the development of a proposal to seek funding for a program involving a complex neurosurgical evaluation and treatment program for the violent inmate. The program would involve the neurosurgery staff of the University of California at San Francisco Medical Center. Initially, following screening at the California Medical Facility at Vacaville, a period of acute hospitalization would be involved at the UCSF Hospital for a period of 5 to 7 days. After this, during a period of two or three weeks, the patient would undergo diagnostic studies, probably on an outpatient basis, being transported as necessary from either California Medical Facility at Vacaville or San Quentin. During this time, surgical and diagnostic procedures would be performed to locate centers in the brain which may have been previously damaged and which could serve as the focus for episodes of violent behavior. If these areas were located and verified that they were indeed the source of aggressive behavior, neurosurgery would be performed, directed at the previously found cerebral foci. Finally, if it were found that surgery was indicated the patient would be rehospitalized at the UCSF Medical Center for its performance.

It is estimated that the total effort, including the necessary screening by physicians, the hospitalizations, pay and transportation for correctional officers would amount to $48,000; grant funds required would be $36,000 with the Department of Corrections providing the 25% in kind match.

Very sincerely,

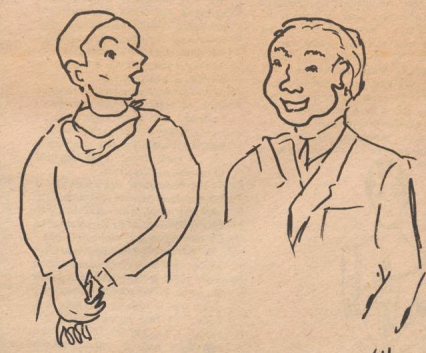
R. K. PROCUNIER

pig

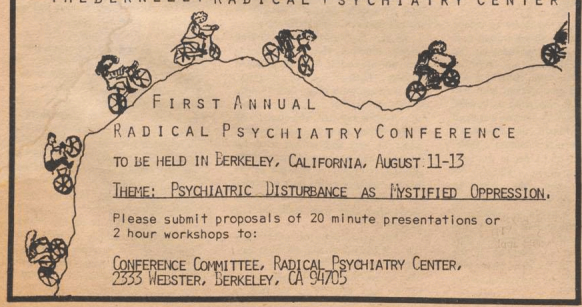
BOOK OF THE MONTH AWARD

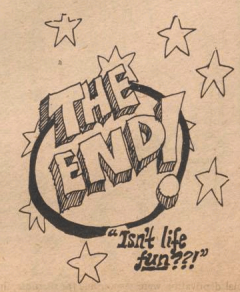
Given for service to the ruling class beyond the call of duty and payoff, to the $15.95 bargain by Robert L. Noland, *Industrial Mental Health and Employee Counselling.* A duplicate award is given to the publisher, Behavioral Publications, whose description of the book we quote (emphasis ours):

> This long awaited book provides an incisive and comprehensive overview of *the impact of problem employees on the goals of industry.* Articles by academic, medical, and industrial experts examine the various approaches companies have taken in anticipating, discovering, understanding, and dealing effectively with *employees who do not conform to the social-vocational roles demanded by their jobs. . . .*



". . . And the really great thing about lobotomies, Senator, is that compared to the cost of bank bombings, strikes, FBI surveillance, and prison riots, there's millions of dollars saved in the national expenditure!"


THE BERKELEY RADICAL PSYCHIATRY CENTER
FIRST ANNUAL
RADICAL PSYCHIATRY CONFERENCE
TO BE HELD IN BERKELEY, CALIFORNIA, AUGUST 11-13
THEME: PSYCHIATRIC DISTURBANCE AS MYSTIFIED OPPRESSION.
Please submit proposals of 20 minute presentations or 2 hour workshops to:
CONFERENCE COMMITTEE, RADICAL PSYCHIATRY CENTER,
2335 WEBSTER, BERKELEY, CA 94705



THERAPIST TURNED WOMEN

by Pat Webbink
reprinted from Off Our Backs, December, 1971.

I feel a conflict as a therapist, between wanting to be real and at the same time hiding behind my pedigrees and playing an uptight shrink role. Sometimes I feel fragmented, trying to be "distant,competent , and strong" when I may feel loving, sad, angry, frightened. If I try to help others to be comfortable with their human needs I must be comfortable with my own. Some of the training I've had is especially difficult to unlearn because it reinforces culturally learned fears of openness and intimacy. Do I dare let it all hang out? I thought I would try in a protected atmosphere and so I decided to put in my two days at the fall meeting of the Association for Humanistic Psychology. I hoped that there I would meet others who were also trying to find truth and change in a traditionally uptight profession.

I walked into the Washington Hilton Hotel. A bunch of "professionals" who had taken off jackets, ties, and mini skirts at the American Psychological Association convention had changed into bermuda shorts and hot pants and had emerged as the Association for Humanistic Psychologists. What resulted was a pitiful display of people trying to release their ids for professional masks. And I was there--lady shrink seeking meaningful change in a rigid profession.

"Power to the Person" was the engaging title for the conference; better stated it was "Power to the Penis". Not only was the male domination as heavy as it is in straight conventions, but here the rhetoric of humanism and liberation were permission for quick lays. Anywhere one turned, there were strangers pawing one another. Not to conform was "unhumanistic". What was even more baffling was that there probably were some very real interactions taking place, but it was impossible to tell how genuine people were. There was so much phoniness, that a person seeking genuine contact got lost in the crowd.

My first meeting was on "Risking my Craziness--Letting Go." The description attracted my attention: *The ability to experience and be my craziness is extremely threatening. My controls become greater and greater until my controls are out of control, and I become what I fear. This experimental session will explore methods for experimenting with one's ability to let go, to risk* his *craziness, and to enter the twilight zone of* his *existence.*

Several hundred people were patiently waiting for the meeting to begin. Five pricks came running out screeching "Let's clap for ourselves." Before I had a chance to question what's so special about us that we should clap for ourselves, the audience passively obeyed and began clapping, yelling and shouting for joy. Did they really feel this? I got up, "Why isn't there a woman on your program?" I got a blank stare for a reply "Are you crazy lady? One of those libbers, eh?"

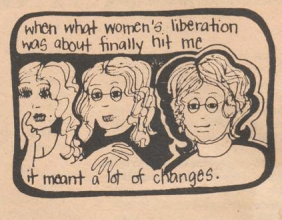
We were then told to get on our hands and knees and play like snakes or cars in a traffic jam. Picture several hundred screaming, pushing humanist psycho-therapists on the floor hissing at each other, "authentic" "real" "in touch." Then we were told to be baby kittens. A man came up to me and had the nerve to play "mating dog." I did have to give him credit for having the guts to be blatantly sexist rather than conformist, as everyone else was being.

The meeting turned into a humanistic hug session – male strangers having a high from the superficial meeting of bodies, feeling that they had engaged in meaningful emotional communication. No wonder the convention is called human-is-tic, that is playing at being human. They will return to their jobs with a renewed sense of hope, with the courage to brave the next year of boredom. I was told by one therapist that for him the convention was a refueling job. I guess if one needs this kind of fantasy, one creates it.

The convention was a carnival. I traveled from session to session hearing that each MAN had the ENLIGHTENED ANSWER. Each had his own ego trip to share with you– why he was a better theRapist than anyone else, how people came to him from miles around after exhausting all paths of salvation. Occasionally there was a mumble of false modesty. "I find myself making mistakes." To add to the mystique, everybody had an unpronouncable name for His therapy: "The transpersonal, bioenergetics, orthomolecular approach, hyperemperia-experiences beyond hypnosis, rolfing." A little of this, a pinch of that; borrowed techniques of massage, touch, yoga, astrology, zen, hypnosis, Buddhist meditation, hypnosis, drama were glorified into The Therapy.

I moved into the lobby to escape all of those men walking around as if something was poking them up the ass. I heard "Step right up. Join the Women's Caucus table next to a stylishly bearded stocky man who was doing his thing, liberating us hussies."

The meeting that evening was open to men and women, the afternoon's solicitors were seated behind a table, while the rest of us peons were gathered around them. Clearly the agenda was closed. We arrived to discover that we were to correct and comment on a group of resolutions which had been drafted by this "liberated" group the night before. Having the honor of deciding if the commas were in the right place, gave us a real feeling of communal democracy.



The women who read the resolutions repeatedly stated that although they had complaints, the Association for Humanistic Psychology was nicer to women than other organizations and that as women we should be very grateful. As she read through one of the wordy announcements, she told us that we should work to make the resolutions concise because that's what men like and we were submitting our pleas to an all-male board.

Several of us finally walked out to discuss the issues which were vital to us– not commas or pleasing the guys– but how we as women could work to free ourselves and our sisters from the oppressions which we all are fighting. We shared what we were doing in different cities. There was a much needed feeling of sharing and communicating.

One woman was organizing her campus doing consciousness-raising exercises which helped women to become aware of their feeling about themselves, their sisters and their dependence on men. I thought about my work and I told how the women I work with and I are growing together, we are beginning to take equal responsibility in our group for expressing our feelings and being sensitive to each other.

When I feel I've communicated with someone in a very beautiful way, I try not to accept that as a qualification for "guruship", like my brother-therapists at the humanist bash. When I walk our of a therapy hour caught up in my own magnificence humming "Jesus Christ Superstar", I stop and remind myself that I'm still the same ol' imperfect being who runs from closeness, finds it hard to cry and oppresses others.

A woman seeker (a better word than patient) after several months in therapy called to say that she did not want to continue. She reluctantly agreed to come in and talk about it. I felt powerless, scared of losing someone I cared about. I wanted to keep her. The only thing I could think of doing was to indirectly manipulate her into staying. I thought of making some esoteric interpretations about her "resistance", using scare tactics such as suggesting that it would be self-destructive for her to leave.

As the day approached, I found myself thinking about her, feeling very uncomfortable with my planned strategy. Then at 3 AM one morning, my defenses were down and I began to cry and to face my fears of losing her, of being rejected, abandoned. As I came closer to my feelings, I became closer to hers and to her need for freedom which she had never been allowed at home. I thought of the way her parents would have mystified her by saying they were meeting her needs when they were really meeting their own.

I felt a real sense of inner liberation. When she arrived the next day, I told her about the process I had been going through. I reached over to her and said "You are free to leave. I really mean that." Without a lot of explanation between us, she and I knew that a new type of relationship was possible between us. Now we are able to relate to each other on a much deeper level. Sometimes we laugh, cry, hug and kiss.

Unfortunately, by accepting my title as psychologist, I imply that my actions are in the name of authority, that if I am effective it is because I am a "professional." How ironic! Because, when you and I touch, it is often in spite of my professional "trimming" and not because of it. As a professional, I was taught to share little of myself, to remain distant and objective. There are some realistic reasons for this. As a professional, I am more legally accountable, and vulnerable for my activities. Also, because of the fact that people often project strong demands of perfection on to the therapist, they can become irrationally infuriated at me. That's scarey. It gets lonely up there on the pedestal, and I'm sick of playing phoney games which alienate me from myself and from others. I want to put my feet in the water – no matter how polluted – and groove on that sense of community and sisterhood that I had never found before I became involved in the women's movement. I want to share my new found meaning to life with other women.

Yet, I want to resist the temptation to become the instant humanistically humanist, the liberated lady shrink, the heavy in the movement.

We have a beautiful movement. Let's not run it into the ground by becoming defensive, rigid adherents. We must not claim, as our humanistic friends that we have The Answer. There isn't any. We do not need to hide out in the women's movement with our problems. We should gain strength from the movement for our personal liberation and to help us free our sisters.

Our strength comes in the courage to be open, to admit the painful confusion of not knowing it all. We can not counter all objections, we can only know that although we haven't got The Answer, we sure as hell are on the right path.

I hope we'll work to create a center for women where we can go when we need to be with sisters, night or day. It should be a place where we can freak out, if need be and know we are in a safe and loving atmosphere, a place where our vague feelings of dissatisfaction with the boxes we've been put in for so many years – become clarified, where we begin to see why women are plagued with feelings of being ugly, stupid, worthless, inadequate, a place where angry reactions are not ridiculed, or used as evidence of our "abnormality", and a place where we can question society's oppression without being labeled as sick, hostile, castrating bitches, libbies afflicted with penis envy.

WAYS OF AVOIDING CLASS CONSCIOUSNESS

Reprinted from:
WOMEN: A JOURNAL OF LIBERATION, Vol. 2, No. 3.

By: Dolores Bargowski, Joyce Betries, Rita Mae Brown, Cynthia Funk, Anne Rosensweig, Ellen Willis, and many others who criticized and made comments – Working class and working class consciousness sisters, lesbian and non-lesbian, from Colorado, New York and Washington, D.C.

This article is aimed at our more privileged sisters in the movement. Many of the values of the Women's Liberation Movement are not the values of working class women but the values of upper middle class women. When working class women have tried to speak out concerning the needs of working class people, we have been ignored, disbelieved, and often told to shut up. We realize that it is painful for women to recognize that they oppress other women but it is a fact. Heterosexual women oppress homosexual women, white women oppress black women and middle class and upper class women oppress working class women.

The following is a list of ways in which middle and upper class women oppress working class women and the ways in which this has been acted out in our movement.

1. Disbelief: Not really believing it when a person in a class lower than your own tells you her experiences because they aren't similar to your experiences. Perhaps her experiences sound too melodramatic and horrible to be true. It seems more like the plot from a book or a movie scenario rather than the real experiences of another human being.

2. Prejudice: Having a pre-conceived idea of what it means to be working class (or black or a lesbian) when you yourself are not working class. Your ideas have not been formed in contact with working class women. You don't believe that people are working class if they don't fit your pre-conceived idea and you leave it at that, refusing to be criticized or accusing the working class woman of lying. Perhaps you think that working class people are all sloppy, dirty, lazy, loud, stupid, dishonest, lack manners, etc., etc. If a woman can articulate her ideas you may doubt that she is working class because working class people are supposed to be inarticulate. You may assume that working class people have no culture. For example, you may believe that the opera is an educated pastime, ignoring the fact that it is a part of the life of Italian working class people.

3. Blindness: Not seeing the working class people when there is a gathering. You don't give working class people the same quality of existence that you give upper and middle class people. You don't notice the working class people. For instance, never remembering your waitress's face because you don't consider her on your own level. She is just there to serve you. Working class people are a faceless mass to you, not individuals.

4. Patronization: Treating people like children if they display less education than you. Talking down to them or thinking them lazy or stupid because they didn't finish their education. ("I don't know what's wrong with them, they don't want to better themselves.") You can't admit to yourself that you aren't more intelligent than other people, only more privileged. This can come out in the form of making fun of people who don't have your kind of book knowledge, criticizing bad spelling, imitating and joking about speech patterns that are different from your own.

5. Self-Criticism: Depending on the people in the class below you to criticize you. If you aren't criticized then you must be doing all right. You avoid self-criticism. You refuse to do something about oppressing the people in the class below you unless they tell you exactly what they want and set up a program for you. In other words, you let them do your work for you. This can also take the form of insisting that you understand absolutely everything about class oppression before you will relinquish some of your own privileges or try to use them to the advantage of working class or black or lesbian women and thereby begin to stop oppressing others. This is not only a stall, it is unwillingness to struggle, because understanding increases with action and involvement.

6. No Trust: When a working class woman confronts you with your class supremacy you don't believe that you are actually oppressing her because you never felt very oppressed by the classes above you. Since the quality of your oppression is not the same, you discount her very real oppression and refuse to see it as an important issue. You don't trust the woman confronting you because you think she is making a big stink out of a "tangential" issue such as class and she is copping out on the "real" political issues. Or you may think that by emphasizing class she is covering up for something else, some lack in herself.

7. Reinforcement: Getting support from other privileged women who are having trouble dealing with the problem of class. If you all agree then how can there possibly be any validity to the few women who are raising the class issue.

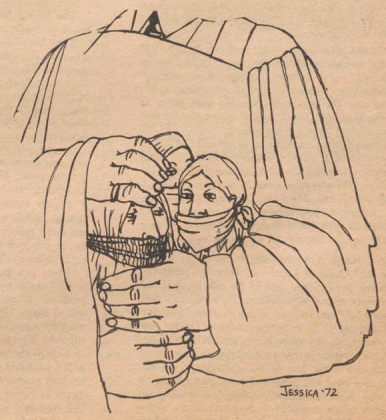
8. Avoidance through Manipulation: Telling a person in a class below you (whom you are oppressing) that she is too hostile and she, in fact, is oppressing you by her hostility. Not recognizing that the upper and middle classes place a great emphasis on covering up differences and hostilities and demanding that people be "nice."

9. Personality: Insisting that when you are oppressing someone in a class below you that it is just a personality conflict.

10. Individualism: Telling a person in a class below you to deal with your ideas and not your personality. Ignoring the fact that many of the things that you consider part of your individuality may be based on class privilege. These things can show up in dress, tone of voice, mannerisms and are avoided by saying that they are parts of your individuality. This is not to say that we aren't individuals, but before we can assert our true selves we must know how much of our behavior is rooted in class backgrounds.

11. Language: Ignoring the fact that "educated" speech patterns are made available to a small percentage of the people. Language and speech patterns serve as a way to classify people. You may insist that a working class person speak in your own way without realizing that she has not had access to those speech patterns. You may tell her to express herself in a "rational" way, *i.e.* your language. This can also be turned around and you might attack a working class woman who has fought for an education and does, in fact, speak the "educated tongue." You then discount her because she doesn't speak "poorly" so therefore she can't really be working class. Educated language very often disguises and talks around problems rather than facing them head on – this helps preserve niceness – and prevents people from attacking their oppression.

12. Role Play: Putting down lesbians who engage in heavy male-female role play. You may think that this is a basic pattern of lesbianism (and therefore put down lesbianism as a microcosm of heterosexuality) when in fact, this behavior is directly linked to class and race backgrounds and is an acting out of oppression.



13. Unity: Glossing over differences between women (class, race, lesbianism) because struggling with those issues is "divisive." This is pure bullshit liberalism and can only work against the interests of a strong, international Womens' Movement. We must learn from our differences and by examining those differences we can discover our true commonality, our true needs and we can then work toward the liberation of all women, not just the liberation of a privileged few.

We have tried to illustrate class supremist attitudes and behavior; we are not attacking a person's background. None of us had any control over the class or race into which we were born and raised. However, we do have control over whether we will or will not continue to oppress other people once we recognize class, race and sex preference privileges. We know that revolutionaries will come from all walks of life. But today we know that we are also still oppressed by our upper and middle class sisters in the movement. We want to show our sisters their mistakes; we do not want to be class supremists in reverse. If our movement continues to focus on the needs of the middle and upper class women and if the ideology continues to come from their values, we know that our needs will not be met and that the movement will oppress us and be taken over by the opportunists and counter-revolutionaries. We want the liberation of all women everywhere and to that end this paper is pledged.

PSYCHOLOGY AS A SOCIAL PROBLEM

AN INVESTIGATION INTO THE SOCIETY FOR THE PSYCHOLOGICAL STUDY OF SOCIAL ISSUES (SPSSI)

Lanny Beckman

EDITORIAL INTRODUCTION

There is a misconception that the Society for the Psychological Study of Social Issues (SPSSI) began as a radical organization and was later either co-opted or turned to the right on its own. To provide some background for the following article and letter by Lanny Beckman, we have checked out the situation thoroughly, including reading much material from all issues of SPSSI's publication, the Journal of Social Issues *(JSI), which began in 1945.*

Beginning in 1936, SPSSI was no more than a group of psychologists who considered themselves applied psychologists: this included a large number of industrial psychologists, people who were attempting to 'cool out' workers in large factories so that the machinery of US capitalism would run more smoothly, insuring greater profit to the bosses. Gardner Murphy, Gordon Allport, and Kurt Lewin were among the prominent 'heavies' in the early days of SPSSI. Lewin was at MIT with his Research Center for Group Dynamics, a precursor of modern-day think-tanks which specialize in working out systems of repression to be used by the liberals. A 1947 issue of JSI *spoke of the importance of industrial psychologists helping solve the "morale problem in young textile workers." A year later a whole issue was devoted to industrial psychology, supplying important information on how to squeeze more out of workers while making it look like a beneficial program for them.*

In the McCarthy era, SPSSI played 'cold warrior' along with the majority of the intellectual/academic community. Ernest Melby, in a 1953 JSI *article, wrote:*

> *By now there can be no question in informed minds where the university faculties stand with regard to Communism. They are as opposed to Communism as Senator McCarthy. They have been opposing it longer and more effectively, partially because many of them are older and also because they saw the danger of all totalitarian threats long before he did.*

So, the psychology 'radicals' were taking a harder line on communism than the reactionary McCarthy! It goes without saying that SPSSI supported Melby's position, given that the article was published in a special issue on the subject and given that there was no criticism of the article by the editors. Four years later SPSSI picked up on the 'yellow peril,' printing a special issue on "Brainwashing" in China.

What about the turbulent 1960's – did SPSSI side with the black and anti-war movements? Not at all! In 1966 JSI *had a special issue on "Misconception and the Vietnamese War." One of the contributors was Ralph White who had worked for the United States Information Service, a government propaganda and counter-insurgency outfit. White wrote how wrong it was for the Viet Cong to kill the puppet administrators of the Saigon regime, and felt that:*

> *All in all, it seems clear that if democracy is defined as individual freedom, the Viet Cong (like the government of North Viet Nam) permits even less of it than the post-Diem military governments in the South have permitted, and in that sense is less democratic.*

Continuing its pro-imperialist position, in 1968 JSI *printed an issue on "Social Psychology of Developing Countries." The articles investigated all sorts of nonsense psychological classifications without mentioning that US imperialism was the main factor in the material and psychological oppression of the peoples of the "developing countries."*

If imperialists were welcome in the ranks of SPSSI, so were racists. Arthur Jensen, famed for his racist IQ studies, was an editorial consultant for a 1970 JSI *number.* JSI *always couches its politics in psychological double-talk, like a 1969 article on "Motivation and Academic Achievement of Negro Americans" which dealt with testing models which had no bearing at all on the reality of racism in this country.*

Student rebellion received similar treatment. A 1969 issue on "Alienated Youth" contained no articles by alienated youth, only articles by rich professionals who make their money investigating alienated youth. Likewise the special issue of last year on "The New Left and the Old," in which academics (rather than movement people) wrote phony articles about things which movement people feel are integral to their lives. Nathan Hackman, one of the contributors to that issue, is a labor relations analyst and past member of the US Wage Stabilization Board, a professional position which immediately defines him as a strike-breaker. SPSSI's myopic view went so far as to have Armand Mause, editor of the issue, speak of The Village Voice *as a movement publication and C. Wright Mills as a movement "personality." Of course, the black, women's, gay, latino, and other liberation movements were totally neglected.*

Other recent issues of JSI *have included "Socialization, the Law, and Society," without having any articles by prisoners or about prison revolts or political prisoners. Another 1971 issue, on drug use, included an article by Herman Kahn of the Hudson Institute, a major counter-insurgency planner for Southeast Asia.*

None of this is surprising, given SPSSI's role as 'liberal' front for the atrocities of the American Psychological Association.† SPSSI invited S.I. Hayakawa, past SPSSI Council member and notorious for his repression of the San Francisco State College revolt, as a special speaker at the 1970 American Psychological Association convention. And who did they trump up to cool things down when radicals threatened disruption – none other than soft-spoken members of Psychologists for Social Action (PSA) who happened to be SPSSI members. In fact, a large number of PSA members are SPSSI members too!

It is often a waste of time to do exposes of the psychology establishment. But when misconceptions are rampant, as in reference to SPSSI, it is incumbent upon us to present exposes. Part of this is a demand for self-criticism by supposed radicals on the SPSSI Council – namely Marc Pilisuk and Richard Flacks. Another part of it is to clarify our position so that we will not fall prey to the faulty and repressive methodology and practice of groups like SPSSI.

Lanny Beckman, near the completion of his doctorate, and a long-time SPSSI member, writes here of why he quit both graduate school and SPSSI. His feelings, from being in the middle of the shit, give us much important information about SPSSI as well as North American psychology in general.

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†*We speak of atrocities in the sense of the American Psychological Association being the primary professional organization of all types of US psychologists, who do everything from counter-insurgency work and military psychology to more everyday rip-off therapy. SPSSI, as a division of the APA, attempts to play the role of running interference for the repressive psychology establishment.*

NEW FROM THE RESEARCH GROUP:

PSYCHOLOGY AS A SOCIAL PROBLEM: An Investigation into the Society for the Psychological Problem of Social Issues

The Society for the Psychological Study of Social Issues is made up mainly of social psychologists. It is the liberal face of the reactionary sloth of social science. The members have a number of things in common. They are concerned about social problems. They want to apply their "expertise" to the solution of social problems. They earn over $10,000 a year – which enables them to spend a lot of time thinking about social problems and making "responsible" pronouncements about social action.

In case you don't get the point: social problems are their bread and butter. In case you still don't get the point: SPSSI is a *liberal* organization. It's *concerned*. It doesn't do anything and that makes it all the more concerned. As long as nothing changes, SPSSI will be in business. As long as there are social problems like "Negroes" and poor people to be concerned about and to study, those five-figure salaries will just keep rolling in.

When you get right down to it though, SPSSI doesn't really see "Negroes" as constituting a social problem. It sees them as constituting a subject matter. I mean, SPSSI is made up of academics, and academics gotta publish or they might wind up being subject matter themselves.

In its periodical, *The Journal of Social Issues (JSI)*, SPSSI publishes thought-provoking, agitational articles with catchy titles like "The SRS Model as a Predictor of Negro Responsiveness to Reinforcement." The author's summary of this almost randomly chosen article pretty well captures the sort of "expertise" that SPSSI endeavors to apply to social problems. (Note: If you can actually make it through the entire summary, step up your program of self-criticism.):

An attempt was made to demonstrate the relevance of an interpersonally oriented incongruity model – Baron's SRS theory – to understand Negro responsiveness to social reinforcement. Based on the SRS model it was hypothesized that Negroes would find a low rate of approval from a white authority figure, at least under certain conditions, more appropriate and preferred than a high rate of approval. The results of a series of studies carried out with disadvantaged Negro youth suggest that this proposition is relevant to understanding how Negro self-evaluation and task performance is affected by social reinforcement parameters such as type, source, and frequency of reinforcement. The role of such research in broadening the focus of the SRS model from a monistic to a multidimensional conception is also discussed.

The political implications of this viewpoint are blatantly obvious. It is important for students with growing political consciousness to bear in mind that the foregoing summary typifies the most progressive attitude in mainstream psychology. It is also important to see that it is the kind of repressive horseshit that lies behind tempting platitudes about "social action" and "the social scientist's responsibility as a citizen."

I got out of the social sciences by the skin of my teeth – a couple of months from a Ph.D. In the letter below, I bid farewell to the arid field of academic psychology and to the pious little corner occupied by SPSSI. I submit the letter to *The Radical Therapist* in the hope that it might deter students from pursuing the illusion that the tools of social science offer any real solution to the myriad problems proliferated by Amerikan imperialism.

Newsletter Editor
Society for the Psychological Study
of Social Issues
Post Office Box 1248
Ann Arbor, Michigan 48106

Dear Sir:

I am writing to cancel my membership and journal subscription. This is concurrent with my decision to drop out of psychology. It has taken me a long time and a lot of hard work to become a drop-out, but looking back, I feel that it's all been worth it. The decision to quit was not an easy one; I too like the security and fat salary that goes along with having a Ph.D., but there comes a time when you must say no to the bullshit.

I ask you not to dismiss this too easily. I've been around the field for quite a while – six years as a graduate student – and have a pretty good understanding of what constitutes academic psychology. I've received consistently high marks and all of the (misguided) praise that they engender. I have read hundreds of mainstream psychological journals and texts, have passed my doctoral comprehensives, written the first draft of my dissertation and have only a couple of months to complete all requirements. I do not view my decision to quit as either fanatical or foolhardy, but as the first sensible and honest action I've taken since entering the field as a graduate student in 1964.

After almost a decade of formal study, I would like to take this opportunity to summarize my feelings about psychology in general and SPSSI in particular.

Psychology, as defined in North American universities, is a spiritual wasteland. Well, of course, what has spirituality to do with the objective study of behavior? But then, what has spirituality to do with the desolate quality of life in America? I see the two issues as inherently related. Psychology is the study of alienated man, but lacks the recognition that it is so. Psychology is the product of alienated men, men so removed from the meaning of their humanity that they believe that rigor, control, experimentation and statistics constitute vehicles toward understanding human life. Academic psychology is a reflection of American alienation. It explains nothing about the human condition, but is itself a symptom of a poisoned culture and, like that culture, requires explanation and radical change.

Should the world survive the evils in which social science plays its part, historians will look back on the dinosaur of American imperialism and see psychology as a tiny ganglion in its toe. And they will be amazed that for a century, a group of men and women, who pretentiously called themselves Doctors, were so blind as actually to believe that the methods of science could illuminate anything of the human heart.

Well, these criticisms apply equally to fields such as contemporary philosophy, but where psychology differs is in the fact that it is also an intellectual wasteland. The level of intelligence one finds in mainstream publications is astonishingly banal. Psychology is an object of ridicule among intellectuals. How often I have felt embarrassment when a friend has glanced through one of my books and shaken his head at the pathetic simple-mindedness aggrandized by inflated psychological jargon. The best minds in the field are third-rate thinkers.

What a tragedy that students who bring to their freshman course the naive and healthy desire to study the "meaning of life" are exposed to the ignorance and reactionary platitudes that parade under the banner of psychology. The best students continue to leave the field. I take this to be a hopeful sign. The liberal rejoinder that the student ought not to reject, say the experimental method, until he has familiarized himself with it is nonsense. Wasting several years familiarizing oneself with the valueless is wasting several years. One function of a teacher (to use an obsolete term) is to encourage students to avoid what is worthless. The psychologist who does so, however, finds himself out of a job. It is my conclusion that psychology has nothing to teach and will eventually find itself without students.

As far as SPSSI goes, I find it in many ways the most objectionable branch of the psychological establishment. If anything, its intellectual impoverishment is even greater than the other branches'. It's a tight race, however, and I wouldn't want to argue the point.

From a political – or as you would have it, "social action" – point of view, SPSSI brings into sharpest relief the bankruptcy of the liberal position. Your chickenshit reformism, your "Activists' Corner," your rational consideration as to whether military psychology promotes human welfare (how can men and women of reputed intelligence even entertain such an insane proposition?) – all of these typify the fraudulent and comfortable concerns of over-paid professionals living in a world filled with misery and oppression.

"SPSSI," you say, "provides an important avenue through which social scientists can apply their knowledge and insights to some of the critical social problems of today." I believe that social scientists possess no special expertise to solve social problems. Your record in military, educational, industrial and marketing psychology leaves little doubt that your expertise serves only to create and perpetuate social problems. It's no coincidence that social science has been used by the powerful to make their schools, factories, and wars run more efficiently. The biases underlying positivist methodology co-ordinate perfectly with the needs of the ruling class: the separation of subject and object; the concern with external, measurable behavior; the preoccupation with method rather than content; the need to manipulate, control and predict. Again, it's no coincidence that terms like "manipulate" and "control" are desirable in the lexicon of social science and pejorative in the vocabulary of social ethics.

The myth that scientific methodology is value-neutral, and that therefore social scientists can beneficially apply their knowledge to social problems, is false. To be sure, most SPSSI members would agree that regretably much applied research in the social sciences has been used to reinforce rather than alleviate problems. But then, they would go on, that is not the fault of the methodology; no, that's the fault of the application of the methodology. For methods are abstract tools; it's up to us how we use them, etc., etc.

I reject that line of reasoning. I don't believe in the separability of method and application. Both evolve interdependently in a context of specific political and economic realities. Who controls the funds to support what research? Mainly, as we all know, government, military, industry and its tax-exempt foundations foot the bill for research which sharpens the tools of "value-neutral" methodology. And, as most of us know, they do so because that methodology, when applied, serves their interests. Workers produce more; consumers buy more; inhabitants are made more docile in concentration camps called pacification centers.

The entire network of research projects is strictly controlled economically. There is no academic freedom. That's another fake myth that SPSSI fights so tenaciously to uphold. And there are no data. The world isn't given to us: it's created. The belief in data is one more piece of the positivist pie baked up by SPSSI, science and the established powers. As Laing says, the things gathered in research are *capta*, the things which have been seized.

And SPSSI seizes at every turn the things which betray its avowed intention of mitigating social problems. You study blacks, the poor, hippies, radicals, delinquents, the emotionally disturbed – all the groups your government tells you are problems. The oppressed *are* problems; they threaten vested interests; they have to be understood and boiled into the putrid soup of American culture. And SPSSI is there, Johnny-on-the-spot, to study them, to understand them, to help the system accomodate them.

Hopefully, the giant machine, which you strive so sanctimoniously and ineffectively to lubricate, will one day grind to a halt. *(We're not so sure that SPSSI's lubrication is so ineffective, and the machine will have to be halted by the people – RT).* And then your most catastrophic expectation will have come true: there will be no research funds with which to study social problems. Or worse yet, there may not even be any social problems.

My conclusion after four years as an undergraduate and six years as a graduate student is that academic psychology offers me no knowledge or insights about the social world in which I live. Rather, it consistently beclouds any understanding.

I have always disliked the pompousity with which psychologists have named their ignorance science. The situation reaches absurd proportions, however, when SPSSI couples that pompousity with pious resolutions about social action. Logical arguments aside, my visceral reaction against SPSSI is provoked mainly by the relentless strain of self-righteousness that runs through everything you publish.

You are a group of men and women earning hugely inflated salaries, while in its name retarding social progress. Consider whether you would be willing to take a cut of $10,000 a year to see the "social problem" with which you are professionally concerned disappear. If your answer is no, I advise you to return to the less hypocritical lie of doing socially irrelevant research. If the answer is yes, I encourage you to sacrifice the remaining thousands of dollars, get out of the field, and join forces with "your" oppressed group to change the conditions responsible for its misery.*

I would like you to print this letter intact as I believe that it is relevant to the entire SPSSI enterprise, that it speaks to a wide cross-section of your membership and that it articulates that sliver of doubt which pricks the liberal conscience now and then (especially late at night). If you are offended by the obscenities, you may change "bullshit" in paragraph 1 to "hypocrisy" and "chickenshit" in paragraph 9 to "cowardly."

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*There are other possible choices which I have not mentioned. The most important of these would be to remain in the university and to work for genuine social change *there*, i.e., in the social sciences themselves. As I state in the titel of this article, psychology is itself a "social problem" and not a tool for solving other problems. This is a fact which most psychologists fail to recognize. This failure leads "concerned" psychologists to apply their energies toward helping external groups, without realizing that the very structure of the psychological establishment militates against effecting real change in these external areas. To make a point which is more than merely an analogy, progressive whites had to realize that the black problem was really a white problem. Psychologists must also realize that the problem is theirs. The solution lies, not in studying "Negro Responsiveness to Reinforcement from a White Authority Figure," but in studying – and working to change – the psychologist's responsiveness to reinforcement from research funding agencies. *(further communication from author – RT).*

In my mother's mind
there are many
vacant lots
full of unwanted
dolls
and kitchen pots
and iron
her mother
dead in childbirth
her
an unwanted
daughter.

And she passes on to me
a legacy
a bible
of distrust of
men
who pass
those vacant lots.

Diang

MENTAL PATIENTS' LIBERATION GROUPS

Baltimore	109 S. Gilmore
Boston/Cambridge	c/o Old Cambridge Baptist Church, Cambridge
Harrowdale	c/o *RT*, P.O. Box 89, West Somerville, Mass.
New York City	*Mental Patients' Liberation Project* – 56 E. 4 St., N.Y.,N.Y.
	Mental Patients' Political Action Committee – c/o Piturro, 357 W. 259 St., Bronx, N.Y.

PEOPLE'S PSYCHIATRY SHEET 2: Drug Emergencies

Chuck Robinson

There are three common drug emergencies where your concerned intervention can help someone, and even save their life. These emergencies are freak-outs, overdoses, and chronic drug emergencies.

FREAK-OUTS Not all psychedelic experiences are positive. There is no way to predict whether or not you, or someone else will have a partially bad trip ("bummer") or an extremely negative trip ("freak-out"). When a person is in a mildly frightened place, or is afraid that they may "burn," they may frown, appear tense, or mention the fact that they are getting scared. A brief "It'll pass soon, just ride with it. If it gets bad, let me know," said with relaxed concern will usually aid the tripper in their search for a more positive space and experience. Extensive questioning, or unreasonable anxiety on your part can make the situation worse. Stay calm, and reassure the person that you will be there if you are needed.

A person can also find themselves in a bad place without warning. The dominant emotions experienced (but not necessarily articulated) during a freak-out are fear and helplessness. Intense fear or disorientation on the part of the tripper allows you to differentiate between the person who needs help and the person who only needs reassurance. On a freak-out, the person may scream loud and long, become agitated, become unable to "contact" another person, sob uncontrollably, or retreat to a corner and tremble. You can intervene in these crises in such a way as to relieve the tripper's anxiety and aid him in relocating hemself within a more positive space.

Make contact with a calm question such as "Are you in a place you don't want to be?" The person may respond, or continue to freak. Don't be hurt or frightened if she doesn't respond immediately. Unaggressively continue with surface questions or statements. "When did you drop? Do you want the music on? Where are you at now? I'm here to help you. You are here at your place with friends." Give the tripper a handle so that she can contact you. Try to let her know where she is, that it is a safe place, that she can trust those she is with, and that the bad experience will pass. Listen, and offer reassurance. It is often helpful to tell the tripper to "flow with it, let go. It will all be clear later. Relax, let go." Avoid ridicule, censure, and playing guru – don't attempt to make sense out of the verbal content for the tripper. Encourage her to talk. Respond simply and honestly. The person will usually get comfortable within an hour. It is well to have a second person with you, or close by, if you are helping a person bring himself down. If you get tired, the second person can take over. It is best for the three of you to spend time together before the first helper leaves. If the tripper becomes violent, be cautious. Restrain only when he actively strikes out. Frightened people are strong and aggressive when they imagine an attack on their person. Call more friends, or stronger and more experienced friends. In this situation, and other drug emergencies, don't get in over your head. Don't be afraid to request help, or back off from a potentially dangerous person. You may have to call an ambulance. If this is necessary, try to accompany the person to the hosptial. Follow them so that they don't get fucked over. If a person becomes unconscious, or begins to convulse, get them to a hospital immediately.

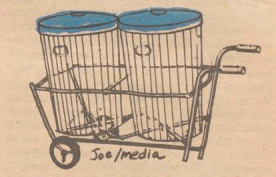
You can use the same approaches with a person who has an acute panic reaction on grass (this does happen – usually with an inexperienced smoker or people who turn on when they are already in the midst of a stressful emotional state) or people on speed runs. A word on speed. There are reports of fatal overdoses on speed. People can also become violent and paranoid on speed, and extremely depressed after a run. People who use a lot of speed are in the midst of a chronic drug emergency. Urge them to seek structured help.

It is a poor idea to give downs or tranquilizers to a person who is freaking out. The drug you give may initiate a dangerous situation in the person's body. You never know what is in a tab that is said to be acid, mescaline, etc. Secondly, aborting a trip with the aid of drugs may prevent a person from working through the difficulty which brought on the bad trip. This may be the cause of flashbacks. It has been determined that depriving a person of dream time can cause flip outs. The situation where you abort a trip with another drug is quite similar.

DRUG OVERDOSES Most fatal overdoses result from an excess of opiates, barbiturates, or combinations of barbs and alcohol. When people inject drugs, they sometimes "go under" right after they shoot up. They come around or someone slaps them awake for a brief period of time. Then they nod out again. Lots of times they never wake up. The drugs have depressed breathing beyond the capacity to support life. People take fatal od's hours after they get off. It takes a while. You can play doctor and shoot them full of salt, coke, or speed, waste time, feel important, complicate an already dangerous bodily condition, or you can get them to an emergency ward as fast as you can. The tools and skills to save an od victim are to be found only in a hospital. Being in the middle of an od situation is frightening in that someone may be dying, and to save them you may have to face the possibility of doctor and cop hassles. But then it is equally confusing when someone dies in your presence. There is always realistic guilt. Disposal of a dead person's body is heavier than a run to the emergency ward. How do you respond? Stash any drugs you have on you. Try to slap the person around and get them walking. Head for the nearest hospital, or call an ambulance. Meet the ambulance outside – say you found the person there. If you can get them to the hospital, do so fast. Once again, say you found him outside your house. The police or hospital officials have no right to detain you. You are simply a good citizen helping a fellow, though unknown, citizen. If the person stops breathing, start mouth to mouth. Tilt the head back, remove foreign objects from the mouth. Pinch the nose closed and breathe a lung full of air into the victim's mouth.

The chest should raise and then deflate again. Repeat until the person can breathe on his own. Don't wait for the person to stop breathing before you respond. If you can't slap a person awake, head for the hospital. If the person comes around, don't let them go under again, and don't leave them alone. If a person has oded on methadone, he can be fine for two hours and suddenly die. Methadone is very long acting. The same is true of barbiturate overdose. A person often cops barbs at intervals. The ones he took an hour ago may knock him out, but the pills he dropped twenty minutes ago will kill. Never try to induce vomiting unless the person is quite alert. Usually, inducing vomiting is effective only in the first 15 minutes after a person drops pills. Any later the person will strangle on their vomit because their gag reflex is knocked out. In the hospital the stomach can be successfully pumped.

The od victim has put you in a funny place. It is she who has taken the overdose, but you must decide whether or not to attempt to save her life. You have to deal with those changes. He has to deal with the hospital changes. You don't have to take any "Why the fuck did you take me to the hospital? I would have been ok," bullshit from anyone who gives himself a drug overdose and starts to die in front of you. Their response is only one of guilt. It is not unhip to save someone's life.

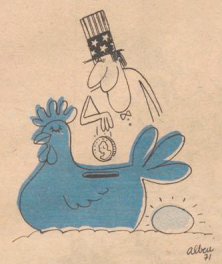


THE MOST COMMON DRUG EMERGENCY The most common drug emergency happens to millions of people every day. They are slowly killing themselves and destroying those around them with downs, speed, heroin, and alcohol. If this is you, or someone you care about, there is a drug emergency. These people don't do it alone. They have more than enough help from our society. America has the best of everything. If you want the best drugs there are for fucking up people, America has these drugs. A mime of our cultural madness is what people do to dance their death dance with America's drugs. With Thorazine hospital oranges, with Mexican reds the CIA-Federales ignore in their macho shoot-outs with peasant grass growers, with the princess amphetamine that wires a person into a "groovy chick," with federal tax, state tax, sales tax, value added tax, tax stamp, tax stamp inspector, assistant chief tax stamp inspector, chief tax stamp inspector, director of chief tax stamp inspectors, nicotine and alcohol, with killer street acid for children, with political mafia smack, scag, duja, junk, horse, dope, tagic majic, boy, heroin, shit, shit, shit. If you, or someone you relate to, punches a hole in their arm, there is a drug emergency. If you are on a speed run, ask the wall people if you have a drug emergency. If you can't sleep without barbs, or you wonder how many goofers are behind your bottle of wine, someone is telling you something. But maybe you can't hear anyone because you found out there isn't anyone there. Do you put so many drugs into the only body that you have, that you have lost your body and locked your mind into itself and you are all alone, all alone? If this is your reality, seek out a change with others who are changing. You cannot change yourself alone, or with others who are not changing, or without others who are changing. Those who will accept you are here, but you must find them in fucked-up America. Only you can find them. They are there.

If you really care about someone who is in a constant drug emergency, you know what to do. Try to discover a way of communicating this to them. If you always scream the message, whisper it. If you always whisper, scream.

CRISIS IN COUNTER CULTURE INSTITUTIONS

Michael Glenn



Two occurrences in the Boston area point up a current crisis in counter-culture "rap centers". First, Project Place, the oldest rap center in the East, has been in serious financial difficulty: its staff of sixty people was not paid for two months. And second, various Cambridge area rap centers have joined a pig proposal by the Cambridge Coordinating Committee on Drugs for a million-dollar a year grant from the National Institute of Mental Health – a grant which concerned community groups in Cambridge are trying to oppose. If the grant fails, it will be financial trouble for the Sanctuary, Cambridgeport Problem Center, Pequod, and other groups; if it succeeds, the groups will make explicit what the community has known for a long time – that counter-culture hippy centers serve middleclass white kids but don't care a damn for problems of black, brown, poor white, Spanish or other minority people.

The politics of this are important. Rap centers like Sanctuary and Project Place were started several years ago to deal with problems of street kids: that is, white alienated youth, mostly middleclass, and into various psychedelics, pot, ups and downs. As the street population has changed – to a less middleclass, more poor and working class group – the rap centers, controlled by counter-culture social work types, have shifted to different "alternatives" – group therapy, food co-ops, communes, yoga, meditation, encounter sessions, etc. The centers have become institutions like any other institutions, with their own hierarchies, professional staffs, consultants and career people. Now their main task is to stay alive. In the struggle for staff survival, the centers' "goals" have become increasingly irrelevant.

Rap centers bring "alternative" counseling, some of it by non-professionals, to young people, as well as various referral, legal and medical services. Basically, the counseling stems from the same orientation as straight counseling, except that the counselors usually understand street life better. Still, the counseling is individualistic, often intra-psychic in tone, and middleclass in values albeit with an overlay of togetherness and love. The centers' potential to spark revolutionary/community activity has not come about; instead, they have moved more to do straight social work and to encourage "getting into your heads and your feelings." Consultants to the centers, despite outward groovy appearances, are often traditional in approach; staff differences, as at most mental health places, end up decided by hierarchy position.

Project Place, now in financial trouble, is a diversified institution. It owns a farm in New Hampshire, operates a runaway house, deals with problems of communes in its New Community Project, staffs an emergency van, consults various communities about drug/youth problems, and – in the middle of all this – operates a 24 hour a day switchboard and referral service. The paid staff of sixty all receive the same salary – quite a difference from most centers – even though there is much specialization of labor. In the past, Place has been very successful in raising money from liberal foundations to support its half-million dollar a year budget. Suddenly, however, funds are drying up. Curiously, this happens at a time when Place is beginning to take seriously its role as an inhabitant of the South End and in re-examining its political stance towards the black and Spanish communities which surround it. It is not clear why money is no longer available: but the implications are clear. "Alternatives" cannot survive any longer by being dependent on liberal money – not if they are going to challenge the establishment which supports them.

The CCCD proposal for one-million dollars a year for eight years shows the tendency for rap centers to leap opportunistically for government money in an effort to stay alive. The CCCD is a 24-person committee (including representatives from Harvard, MIT, and the Massachusetts House of Representatives) which purports to represent Cambridge. In fact, only 11 of its members live in Cambridge, 8 of the 11 from Harvard Square.

The Committee includes no representatives from poor, minority or drug communities: in fact, not one poor person, minority group representative, or community person from areas plagued by drug-abuse was ever brought before the committee's meetings. The proposal totally ignores the needs of Cambridge's people, while catering to middleclass, professional interests, focussed at Harvard Square – that is, to middleclass, white, counter-culture youth. All this, in the name of a "comprehensive" drug program for the city of Cambridge.

The CCCD asks for a lot of money for various rap center groups. Its grant is beautifully written, but represents almost total bullshit and exploitation of the community. A central administrative unit, for instance, is supposed to receive $140,000 for eight staff positions and equipment – but it's not clear what they are supposed to administer.

The rap centers have leaped into the proposal, hoping to grease their palms. Cambridgeport, for instance, which is having trouble paying its Psychiatric Director his $15,000/year salary, asks the NIMH to pay it; yet Cambridgeport has no program for drug users, nor does it propose to set one up. It simply states that it is available (in Harvard Square) for drug users.

Pequod, a counter-culture group therapy place run by non-professionals serving middleclass white kids, asks for about $35,000/year for setting up ten groups for ten adolescents each. But there is no provision for any outreach into the community, which leads to the conclusion that NO COMMUNITY KIDS will come to Pequod, just as none or few do now. The money from the grant will go to staff salaries and audio-visual TV equipment. That is, it will keep Pequod alive.

Sanctuary, which had a yearly budget of about $100,000 this year proposes to spend nearly $200,000 next year. It declares its intention to work with non-heroin drug-users, but fails to be specific about this – and then asks the NIMH to pay *90%* of its operating budget for the coming years, including almost all staff salaries, consultant salaries, and so on. Nowhere is it clear that Sanctuary will devote more than a few percent of its total efforts to community problems. In its whole history, Sanctuary has dealt poorly with community people; its staff contains few if any people from the Cambridge community; and it is seen with mistrust by much of the poor and minority people of Cambridge. Yet Sanctuary, with its inflated budget, asks to rip-off almost $175,000 a year in the name of the Cambridge community, its youth, and a drug-abuse program.

If Sanctuary can get the money elsewhere, it should withdraw from this opportunistic grant; if it has no other source of funds – it is in serious trouble.

Many of the groups on the grant put together their proposals within a month of filing time, pressured by the CCCD to act quickly and grab a piece of the pie. The bias to administrative and professional positions is obvious: of the 63 positions funded, only *three* are for community people, and they each require an A.B. degree. Over 50% of the positions funded are administrative or supervisory. Half of all the positions funded are in fact already filled by people paid from other sources.

The only actual treatment program for heroin addicts is one already in existence, at Cambridge City Hospital. Another "satellite" unit is asked for, but that doesn't change the fact that the program is centralized at Cambridge City, not reaching out to areas of Cambridge where addicts live. What's worse, the program is a methadone maintenance program, which medical findings, addicts' groups, and politically-aware people have increasingly opposed: more overdose deaths now result from methadone than from heroin; methadone is harder to kick than heroin; methadone maintenance maintains people as *addicts* and, furthermore, makes them dependent on hospital programs where they can be kept track of, etc. Methadone is a *political* program, to contain and weaken the minority and poor people who become addicts. As the mainstay of the CCCD proposal, it can be expected to oppress and alienate further community people.

Shortly after the proposal was submitted March 1st, the Cambridge Spanish Council and COPA, a community Portuguese group, found out about it and realized they had not been consulted on it. Later, they found out that no low income or minority group had been included on the planning. The proposed "community" program has been unveiled as a farce, and community representatives are trying to devise a strategy for dealing with it now. Some will go to Washington D.C. on March 22nd to protest, and hopefully to regain control of their own community's "comprehensive" drug program.

What emerges from this is the counterculture's willingness to oppress working-class, poor and minority people in its greed to keep its own institutions alive. Catering to alienated white middleclass youth, they manage to rip-off the community's name and legitimacy, while ignoring its people and its problems. The politics of counterculture shows them as exploitative and unconcerned with community feeling as the long-established middleclass institutions have always been. This is no surprise to community people, but it may raise some "consciousness" at the rap centers, especially when funds are scarce in coming down.

Either way, the counterculture places are in trouble. If they get Federal grants like the CCCD proposal, they join the status quo in oppressing community people; and if they lose Federal and foundation funds, they will have trouble staying alive. Perhaps this dilemma is a good thing, though. They cannot postpone taking a political stance much longer.

new university conference has set a tentative date – June 9th – for a conference in Bloomington, Indiana . . . . . by bringing together the people and the practice of several years of professional association organizing, we hope to lay the basis for a united program for education and for cooperation in activity through the coming years. We will also discuss the role of radicals in education unions, in radical teaching, how to actually carry out education for liberation on a day-to-day basis. The final days of the conference will be to discuss the future of NUC. We need your support and interest for the conference to take shape at all. Please send us any suggestions for the agenda as soon as possible:

New University Conference
622 West Diversey Parkway
Room 403
Chicago, Illinois 60614

Imijizm is the practice of discriminating on the basis of arbitrary standards of appearance. There's a report on it called *Beauty is Conditioned Into the Mind of the Beholder.* To get a free copy, send a stamped envelope to:

IMIJIZM
c/o Female Liberation
Ishleman Hall
University of California – Berkeley
Berkeley, California 94720

We would like to hear your experiences with the health care system. Write to us and let us know what your group is doing to organize around lesbian health care issues.

Radicalesbians Health Collective
Women's Center
36 West 22nd Street
New York, N.Y. 10010

Back in the USSR: The Politics of Psychiatry

The Soviet Union is a country we readily (and rightly) associate with the persecution of political dissidents. Many of us have learned in recent years, through long and bitter struggle, to recognize our own country in this same light – indeed, perhaps in the forefront in the use of subtle as well as blatant weapons of suppression. Over the past few months there has been increased attention in the liberal press to the USSR's use of psychiatry and mental hospitalization as tools in the struggle against the growing dissent movement in that country.

While shrinks of some other countries have already protested these abuses and called for investigations, American shrinks, as usual, drag their feet. But pressures are being brought against them to take a stand that's more than a cop-out, and it remains to be seen how the pros will wriggle out of this one. It has apparently not occured to the American journalists that the slowness of American shrinks, and indeed of shrinks the world over, to move involves more than naivete or bureaucratization. The writers treat the Russian evidence as if the Soviets had invented this particular method of dealing with dissent! There has been some mention that the dissenters receiving the persecution (or publicity) are high-placed scientists, among the Soviet and world elite, but no analysis of the common interests that Soviet and American shrinks have in keeping their professional prerogatives, or their common use as tools of the state in supporting and carrying out its ideological goals has been made.

Nowhere in the widely publicized reports of atrocities in the Soviet Union has there been any mention of parallels in our own country. But these parallels in the political use of psychiatry are apparent to anyone who makes an attempt to find them. For example, RT carried in its last issue articles circulated by Liberation News Service, one on the control features of methadone maintenance programs, especially for third world people, and another on the proposals for shock and other punishment-type "therapy" and neurosurgery for "violent inmates" (read "political prisoners") at the Vacaville, California state mental facility. Recent news, carried in daily papers, has told the world of lobotomies and other brain operations being done on increasing numbers of patients, particularly women, and of retarded children being used for experimentation at Willowbrook in New York. And the day-to-day politics of psychiatry continues – in which civil liberties of all sorts are denied except to the rich; in which the poor, the nonwhite, the young, and the female are made to conform by brute force or subtle means; in which beatings, forced medication, aversive therapy, and restraint are not uncommon; and in which the definition of normality in this country is in the hands of an elite whose rewards come from those who control government.

Reports of these facts are much more readily available to U.S. journalists than are those smuggled out of the Soviet Union. But there is a type of political projection practiced here, whereby our country's own crimes are attributed to another (often "enemy") country. Thus, control of news is condemned in South American countries; North Vietnam is accused of aggression at the peak of U.S. attacks; and the Soviet Union is accused of using psychiatry to carry out its political goals. And thus red herrings are thrown out and the heat is taken off our own practice.

BACKGROUND – Medvedev and Bukovsky

The case of Zhores Medvedev has been a central one in organized protest against the Soviet government. In briefest and roughly chronological order, these are the main events: Medvedev, a prominent Soviet biochemist, wrote a book and some underground papers politically unpopular with the Soviet big daddies; he had been removed from his post as director of a biochemical lab but continued to write in the underground. There were several unsuccessful attempts to entrap him into the regional mental hospital. Finally, in May, 1970, he was visited at his home by two psychiatrists of the hospital (one being its head), accompanied by three policemen, all bursting into his apartment uninvited. A long interrogation followed, during which Medvedev resisted for so long that finally a police major, who had expected a sooner conclusion, burst in also. Medvedev's wife called some trusted and respected colleagues to help resist,

SCENE FROM WORLD PSYCHIATRIC CONGRESS

but he was nevertheless abducted by ambulance, while police held his wife's arms. He had, however, been promised that his "examination" would take no more than three days. Of course, this promise was not kept; other conditions of Medvedev's hospital stay were also changed for the worse (visiting conditions, friendly fellow patients, ward, etc.) as outside pressures to release him began to be brought forward.

Big-name scientists and humanists within the Soviet Union, and all over the world, protested his detention vigorously, since there was absolutely no evidence for the usual diagnosis of "mental disorder." Zhores Medvedev was very lucky to have a twin brother, Roy, who helped organize the protest and harassment, and indeed, differences within the government itself, to such an extent that within a few weeks he was released. He was, however, requested to report for outpatient treatment, which he had earlier been promised would not be required (in exchange for his not revealing the story to the world).

After the incident preparations were made to raise the issue of Soviet suppression by psychiatry before the upcoming World Congress of Psychiatry, to be held in Mexico City in Nov. - Dec. of 1971. Vladimir Bukovsky, another Russian dissenter, had sent 150 pages of documentary evidence on the matter to the West around March of last year. Bukovsky has been an activist and participant in the human rights movement, and another recipient of Soviet "justice" in both prisons and mental hospitals. A group of 44 British psychiatrists last September wrote to the *London Times*, with a summary of their study of Bukovsky's documents. They asked the Soviet government to reconsider Bukovsky's case (he was jailed again within weeks after the material was received), and called upon their colleagues throughout the world to study the material and also to discuss it with their Soviet colleagues. They urged also that the issue be raised at international conferences such as that of the World Psychiatric Association (which stages the World Congress). Medvedev was of course free by the time the Congress met, but Bukovsky and others were still in prisons and hospitals.

THE WORLD CONGRESS

In Mexico City, beginning November 28, 1971, about 7000 shrinks of the world met for a week. The issue of Soviet psychiatric suppression was in the air all around the group, and many pleas were made for the Congress to confront the issue and censure the Soviet Union, but this was not done. Right before the Congress convened, the Soviet human rights group and Bukovsky sent messages to it, Bukovsky including the 150 pages of evidence. A pamphlet in three languages, with the findings of the 44 British shrinks, was circulated at the Congress. Later, other speakers demanded that the Congress go on record concerning the issue, but at this point there was a Soviet walkout. This was followed by a whitewashing interview in a Mexican paper with a chief Soviet delegate and perpetrator/collaborator in the very crimes being considered. Others who had wished to raise the issue (including two American shrinks) were barred from the decision-making.

The American Psychiatric Association's *Psychiatric News* in January explained away the inaction of the World Congress by the fact that the WPA had (in the words of the editor) "no constitutional provision or mechanism for adopting a position" and further that "its leaders had no desire to take an action that would have alienated the Soviet delegation..." Richard Green, a N.Y. shrink who had tried to get the Soviet issue on the agenda, said "Organized psychiatry has a very clubby atmosphere. These people visit back and forth constantly. They go to Moscow and have cocktails with their Soviet colleagues and they don't like to blow the whistle on them because they won't get invited back." (*Behavior Today*, 2/14/72).

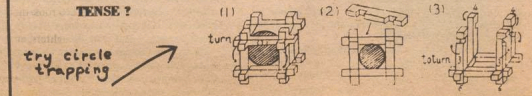
OTHER PROTEST AND LACK OF IT

Outside the World Congress, to which had been directed the most attention, there was some protest elsewhere in the world. In Britain and Canada, shrinks investigated the Soviet issue and reported on their findings, and called for further study; protest came from international groups in Hong Kong and Geneva, but the WPA itself has done nothing. In New York, the Mental Patients' Political Action Committee (MP-PAC) organized a protest rally at the Soviet legation (better it had been at Bellevue).

What about the American professionals' reaction to the furor? Except for those few who attempted to have the matter on the Congress agenda, there has been the usual apathy and distaste for controversy, illustrated by the item in *Psychiatric News*. The trustees of the American Psychiatric Association did, however, take a firm (14 - 4) stand "opposing the misuse of psychiatric facilities for the detention of persons solely on the basis of their political dissent no matter where it occurs." Not naming names in such a statement, of course, avoids the embarrassment of having to point a finger, and may be further justified on grounds that the USSR isn't the only culprit. There is some movement afoot to produce a stronger reaction from professionals, and it may be somewhat successful (because of the pressure from liberals), providing it doesn't come too close to home, but continues to focus on psychiatric suppression outside Amerika.

A particularly interesting facet of the whole issue is the fact that a group of American psychiatrists and a judge published a report on mental health in the USSR in 1969, following a trip sponsored by the Department of Health, Education and Welfare, which

Is there anyone interested in the IPM test devised by Laing et. al.? I would like to hear from you...Phil Brown, c/o *The Radical Therapist*, P.O. Box 89, West Somerville, Massachusetts, 02144



USSR (continued)

contains no mention of the possibility of mental commitment for dissent in the USSR. This "First U.S. Mission on Mental Health to the U.S.S.R." visited the infamous Serbsky Institute, known to dissidents as an arm of the secret police, and gave it a glowing, if somewhat mystified, description.

PUBLICITY

Meanwhile, back in the USSR, Zhores and Medvedev together wrote a book describing the Medvedev incident, *A Question of Madness* (Knopf, 1971). The liberal press carried accounts of the Medvedev events, and gave prominent reviews of that book and related ones.

The New York Review highlighted the Soviet issue in three successive numbers, including a long two - part article by left political analyst I.F. Stone. Stone's article (2/10/72) brings heavy pressure on American shrinks to protest Soviet use of psychiatric treatment for political dissidents. He sent documents to the HEW investigation team and asked for further investigation by them, writing that if they "reject the task of examining these records, then an ad hoc group of American psychiatrists should do what the forty-four psychiatrists did in Britain and make their own report." A weekly behavioral science newsletter spread the news among the biggies who read it by a review of Stone's article on its first page.

Stone's account in the *Review*, besides blindly avoiding the consideration of Amerikan practices similar to Soviet ones, shows at best a naivete that ought not to be found in a left-liberal journal. He writes, for instance, "...new methods for dealing with nonconformists, like the Soviet practice of committing them to insane asylums, may spread from their society to ours." And that, while we may understand the necessity for Soviet shrinks to act as they did in Mexico City, since they could face similar persecution themselves, "...there is no such excuse for the psychiatrists from the 'free world.' " Stone treats the report by the American team as if the doctors and judge were innocent observers who were merely taken in or failed to do a thorough enough job through no fault of their own. Missing the fact that professionals the world over have common vested interests, he wrote that "The fact is that at Mexico City the undemocratic practices customary in dealing with public complaint in the Soviet Union spread to the psychiatric congress," as if the disease originated in the USSR and had to be spread by personal contact.

It seems that the pressure on American shrinks to join the world protest has brought some results: Green is now collaborating with Stone on a full analysis of the documents and also intends to get the Soviet (no mention of the Amerikan) issue on the agenda for the May convention of the American Psychiatric Association.

BEYOND PUBLICITY

Several points stand out in this whole ugly affair: (1) that Amerikan parallels to Soviet persecution are deliberately avoided, and the USSR used as a scapegoat, perhaps to keep the eyes of the world from turning on us; (2) the subjects whose persecution is protested are of a world elite, while millions of poorer, forgotten people suffer from the same crimes; (3) the liberal press, while recognizing somewhat the professional cliquishness between countries and the elitism surrounding the protests, still fails to provide a deeper analysis of the reasons why shrinks will readily execute their government's policies and refuse to rat on each other; (4) that no amount of left-liberal press protests of resolutions from the psychiatric associations of various countries will change the conditions that make the persecution and collaboration so.

To paraphrase Stone (by changing one phrase, "The Soviet Union"), *America will never reach the rule of law until the main sources of lawlessness – its own officials – are taught the hard way that their violations of the law will be punished.* This lesson will come from the masses of people now suffering political persecution by psychiatry.

IN THE ASYLUM

The tired windows sag there
Panes caught in dove-tails
Half-defoliated, lagging
Behind the winds
So bland and brittle
Heart-whistle dessicated
Groaning the fulminations
Of arteries gone dead.

Here the black beacon circles
Heads in a vice, but expanded
To dwarf even the cold stars
So great and blanched, pallid
Reflected in eyes too many
To count, each, garbled stares
Wet death-kisses pursing at them
To suck – but not yet – into a void.

It is white as winter sleep
In a manger for lesser
Men in grey pyjamas, panting nicotine
Over the empty card-tables
With royalty: kings, queens, all deceased
But other games persist, encapsulated
Below these chilly rafter-gallows
Brazen even in their own dusk.

The black beacon circles on
Smacking every face
In turn, gawk-eared and eyed
At a silence that drools
Thumbs set in rotations
Run slow of dire sadness –
This sleep could sharply wake
The sleeping if they saw.

They do not see
And the men are chalky shadows
On an unteaching blackboard
Soldered to the unreachable sky
Dreaming of infanticides they never had
Dusty rats in their houses, parched nostrils
Goodnight to the paltry
Stars, old holes, give no wishes.

TO A PSYCHIATRIST UPON TERMINATING TREATMENT

To Dr. S.

"Alas old endgame, lost of old . . ."
–Hamm, *Endgame* - Samuel Beckett

I was Goya's "Maja" on the couch
The clothed one, of course, although
I was also naked, flayed bare by sentences
About my fantasies kiss-and-punch drunk
On a note-pad; pawn to king four
The clock is a stern master. mother time
Spawning us all into a brackish sea
Leaving us to die, some taste their gall,
And force-fed brine before a damp tomb
No rose-wreaths - only old weeds and algae
Until the bottom swallows; knight to rook three
A glass of water is a poor intoxicant,
Only one more of the same that slaughters, and:
Cocktail party chatter hangs low over the scarce furniture.
It was a nice weekend, save for the rain
And you – I curse you for two years of sallow mornings
Brainly inflamations kindled to a fire and:
A glass of water cannot put them out.
Pawns forward, bishop slashes: castle
We are in the ballroom of a courtly dream
Executing steps apart in a dance of separation
Baring our teeth in smiles less ambiguous
The fillings glitter, but our eyes lack luster now
Made dim by too many stares
And our ears are tuned to such limited pitches
That we do not hear each others' strange music anymore
I harp on but you do not catch the notes.
The pieces shift, cold surgeons' hands
Rip me apart, but the exploration yields nothing new
The same innards are there; but thought kisses pall
And the wheels have now shifted. We both see
The same hours on the dial: early shows drag so
And wit turns to a pointless game of catch.
We have recounted all our mysterious dreams
And the omens are now as familiar as subway-signs.
A bishop daggers right; pawns silently cower.
We have turned into a pair of swine seated
Casting each-other much-wasted pearls:
This must be the endgame.

poetry by JUDY GREENBERG

Become Mentally Healthy or I'll Kill You

JUDY GREENBERG

You're feeling anxious and depressed, but you don't know what you did. In fact, you did not do anything. But there is a policeman on either side of you, and they are taking you to what the sargeant at the station called the "psycho ward". You arrive. A doctor asks you some questions: "What is your name?"; "Where are you?"; "What day is this?"; "Who is the president?" You answer them all correctly. Even the doctor looks satisfied. But one of the cops insists that you are a danger to the public. The doctor squints and rubs his chin a while. Then he perks up and calls for two attendants. "Take Mr. Y to ward 11P." And you did not do anything.

A short story by Franz Kafka, perhaps? No. A typical admissions procedure at Bellevue Hospital's psychiatric division.

(The following is a description of hospital justice compiled from numerous, actual instances; and in fact, all of the incidents described below have happened to certain individuals. It is an attempt to trace the predominent patterns of hospital procedure, carried out by law in violation of civil rights, with the full consent of those who are instrumental in effecting these procedures.)

"Tell me, Barbara, after your father, minister, principal, doctor, dean, and husband, are there any other men that this abnormal hatred of male authority you have has centered on?"

What the person detained without official committment in a psychiatric ward and about to face committment procedings soon learns is that he is being judged in a kangaroo court. It is held within the hospital premises, and the person to be presented is often garbed in pyjamas. The case is stacked. Due to heavy sedation, he often is too debilitated to be able to comment; or if he is able, he is in a position in which he is invariably testifying against himself, since the court is intent upon committing him, and will interpret any of his statements as yet another proof of his derangement. The attempt to protest that he is not crazy is regarded as an indication that he is severely deranged, since, "the sickest patients are those who don't know they are ill." In this Kafkaesque courtroom scene, he is not genuinely informed of what he is being "accused" of; and when the evidence is presented, any attempt on his part to deny the informational content of the evidence is regarded as a symptom of "mental confusion". An indignant denial, given in a loud tone of voice and accompanied by gestures is regarded as yet another indication of the patient's potential for violence.

One would suppose that in these circumstances, the "accused" would be properly informed of his rights and defended by a sympathetic attorney. But here enters the problem of obtaining access to a telephone or a mailbox – an access often denied, rendering it impossible to obtain an independant lawyer and an attending physician. The individual is forced to rely on a hospital-provided lawyer – who usually intends to make little defense out of simple expediency: The legal information channels are supposed to consult with the patient regarding his legal rights shortly after his admission. But in actuality, these consultants arrive too late or not at all. Thus, the person without legal sophistication and having no experience in playing the game is bound to be committed. And this individual is most commonly a member of a lower-class, minority group. Only wealth, a concerned family and an expert lawyer can successfully influence the court – thereby leaving out a vast percentage of the American populace. (Of course bribes have been known to help in certain instances.)

A Man from Philadelphia sent us a letter, asking for some information. One of us took it to answer and lost it. Thus, we ask for apologies and a new letter..rt

Once incarcerated in a public institution, there arises his problem of leaving legally. This can be partially solved by "playing the game", but under the influence of heavy medication, palsied and half-stupored, the person has a difficult time looking normal – only "manageable" (to couch it in hospital terminology). In New York State, after sixty days of committment, the procedings may be brought up again. What presently saves many individuals from recommittment is the budget cut in the Department of Mental Hygiene – which liberal supporters of mental health protest so vigorously. By this time, the white, middle-class male has probably obtained good legal counsel and has beaten a fast retreat homeward under the care of a private practitioner. But the lower-class, Black female is still confined to the dayroom with a flickering T.V. set and a worn pack of cards for another sixty days (*"ad nauseam"*).

While the individual is confined, every attempt is made not to treat him but to ignore him as best this may be facilitated. As Dr. Robert Campbell instructs his students, "Medicate to the point of toxicity and then reduce the dosage one level." This is not a mode of treatment; rather, it is an expedient means of keeping the ward quiet. A patient is expected to take his medication voluntarily, and when it is suspected that he is not swallowing it, his mouth is carefully scrutinized. Should he have hidden the pill and still fails to take it cooperatively, he is dragged to the "seclusion room", forcibly injected, (sometimes beaten), and left in this tiny cell with a mattress on the floor, a drain and a lot of unremoved fecal matter, for as long as twenty-four hours. This is totally unnecessary when the person is drugged into semi-consciousness as regards safety matters. It is instead a form of negative reinforcement designed to convince the patient that he had better take his medication "or else". He is often not permitted access to a toilet, but when he is forced to relieve himself on the floor, it is viewed as being indicative of regression, requiring further confinement in the "seclusion room". If he is in a teaching hospital, he will be treated by an unchosen, training resident (often an orthodox Freudian) whether he likes it or not. If he is confined in a non-teaching facility, he will receive no therapy – again whether he likes it or not. Requests for more – or less – therapy often bring on an increased dosage of tranquilizers and the insistence that whatever the person is requesting is not good for him. Strong recalcitrance over a prolonged period of time may bring ECT or IST. * If the protests persist and the budget is being provided for, he will very likely be recommitted. If the budget is in difficulty and the person leaves, he cannot effectively sue for malpractice, since everything was "done for his own good". By this time he has probably suffered permanent loss of a job, and with his psychiatric history, will be unable to obtain another one.

One would suppose that the "voluntary" does not have to suffer these indignities, but the contrary is the case. A "voluntary" is no longer voluntary once he signs the provided sheet of paper. Getting in is easy; getting out is not so easy. The form, of course, does not specify all that the individual is consenting to, this including – and for the committed patient – forced medication and treatment. Allegedly the patient can sign himself out. But in the private or semi-private institution, the expression of an intent to leave is met with subtle coercion, insistence that leaving will do dire and irreparable damage, or threats (a) that the institution will never take him back if he has further trouble (which they insist will occur) and/or (b) that committment procedings will be instituted to confine the patient to a public facility. In a public institution, either drug dosages are increased, or committment procedings are begun and implemented.

After a year of this, the patient often loses the desire to leave. He no longer has anywhere to go. He has become highly adapted to vegetating. And foremost, the hospital staff has inculcated such terrors of the "outside world" into him that he is dependent on the hospital. This is usually classified as "failure to respond to treatment" in a non-teaching facility. But in a teaching facility, the same behavior would be considered "responding to treatment", even after a year, because teaching institutions have to retain "interesting cases". For females this mode of reaction is viewed as almost healthy, since passivity and dependence are viewed as normal for a healthy female – even if the staff thinks it inauspicious to discharge her due to the same passivity and dependence which they regard as an indication of mental balance.

America has vigorously resisted state religion while intensely favoring state psychiatry, tightly interwoven with the judicial system, yet with a "justice" all its own. "Guilty until proven innocent"; or to use the terms of Dr. Stone of the N.Y.S. Psychiatric Institute, "Patients at my institution are diagnosed as being schizophrenic until proven otherwise." The tyranny of inference. That experiences are open to objective scrutiny is highly questionable. But that a subjective state is "*materia medica*", when the patient refutes the inference of the psychiatrist, without any credibility being given to his refutation, it is a clear example of inequity.

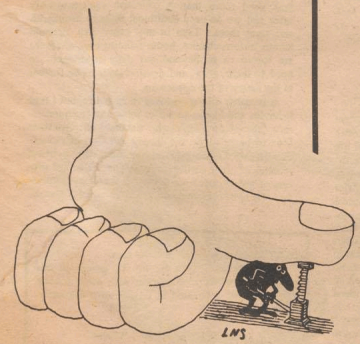
That more than one institutional employee holds a single opinion regarding the diagnosis of one patient is regarded within the institution as a confirming validation – rather than a concordat based upon suggestibility. (The discrepancy between independent diagnoses of a single patient is well known, yet passed off as an argument between schools or equated by an interpretative balancing.) Conference diagnoses are merely a dialectical process where the final analysis leans most closely towards the opinion of the individual with the highest status. None the less, the remarks of the patient on the subject of himself are brushed aside. And psychiatry is regarded as a branch of objective, medical science, overtly coupled with legal facilities, but meting out a "justice" in clear violation of the Constitution.

There are further disguised estrangements between the other branches of medicine and psychiatry, however, which are rarely considered. Institutional psychiatry clings desperately to its medical status, yet while doing so, has a "*modus operendi*" highly discrepant from that of physicians and surgeons. A medical patient has the right to refuse treatment. He may leave the hospital without having recovered. He may even die of his his ailment if he wishes to do so. (This is not viewed as suicide.) However, a "mental" patient may not refuse treatment. He may not leave the hospital at will. Nor has he the option of dying at will. Furthermore, while a medical patient's reactions to treatment are taken into account in determining the course of further treatment – or if there is to be any at all – any comments from the "mental" patient are judged as evidence of increasing health only if they concur with the psychiatrist's point of view. If they do not concur, they are frequently regarded as indicative of illness, to the result that the patient receives even more of the same treatment. The "medical mystique" is so thick as to obscure these crucial differences even to doctors.

It may still be insisted that the patient is "out of contact", whatever the legitimacy of his complaints may be, and that he must therefore be deprived of his rights to protect the "general welfare". But this is a curious notion in light of the fact that a huge percentage of the population consists of those "accused of being insane". Furthermore, the deprivation of civil liberties on these grounds disrupts the balance of majority and minority rights in favor of the majority. Individual rights are crucial, and their removal facilitates the use of institutionalization as a political tool – as it is already to a large extent. Institutional psychiatry as it now stands serves as an economic and social control to remove from the general population those who do not fit into the prevailing economic and social structure – the "social dross" which embarasses the affluent – and those who do not consent to the communal reality – as in the case of rebellious adolescents. This is undoubtedly politics disguised as medicine. And for the individual who attempts to struggle against the system from within, there is nothing to confront but "Catches 22, 23, 24. . .n." Reasonable protest is equated with madness or vehement and malicious radicalism when coming from without.

"Become mentally healthy or I'll kill you!" Whatever mental health is. . . .

(Note: The Supreme Court, in a recent ruling on a case brought up by the ACLU, decided that medication could not be forcibly given to a Christian Scientist, on the grounds that is is a violation of freedom of religion. But what if one's religion is freedom?)



*Electro-convulsive therapy (electro-shock); insulin-shock therapy.

PERFECT HUSBAND / PERFECT WIFE

NOTE: Marriage counselors for years have used the "most popular" quizzes "Are You the Perfect Husband?" and "Are You the Perfect Wife?" We thought it would be refreshing to reverse the sexes on these overworked quizzes and show up some of the sexism which saturates so much of marriage counseling. So here are:

RT'S OWN PERFECT HUSBAND/ PERFECT WIFE QUIZZES

A SCORECARD FOR HUSBANDS

1. Do you try to make the home interesting, attractive, cheerful, a place of rest and relaxation – devoting as much thought and study to that as you would to a job "downtown"? 0 1 2 3 4

2. Do you encourage your wife to go out frequently with her women friends, though it means leaving you home alone? 0 1 2 3 4

3. Do you serve meals that are enticing in variety and attractiveness? 0 1 2 3 4

4. Do you handle household finances in a business-like way? 0 1 2 3 4

5. Do you keep yourself attractive (though not offensively so!) in appearance, in order that your wife may be proud to have everyone know you are her husband? 0 1 2 3 4

6. Are you a "good sport," cheerful and uncomplaining, punctual, not nagging, not insisting on having your own way or the last word, not making a fuss over trifles or requiring her to solve minor problems that you should handle alone? 0 1 2 3 4

7. Do you bolster your wife's ego not comparing her unfavorably with more successful women but making her feel that she is the most successful woman you ever met? 0 1 2 3 4

8. Do you prevent your mother and other relatives from intruding unduly, and show courtesy and consideration to her own relatives? 0 1 2 3 4

9. Do you take a sympathetic and intelligent interest in her business – yet leaving her a free hand, not offering advice, criticism of associates, etc., unless asked; and realizing that she must often give time to her business when you would rather have her give that time to you? 0 1 2 3 4

10. Do you cultivate an interest in her friends and recreations, so you can make a satisfactory partner in her leisure hours? 0 1 2 3 4

The perfect score, made by adding up your mark on each item, is 40. If you score less than 25, you should work hard for improvement.

0 = "never," "not at all."
1 = "somewhat," "sometimes," "rarely," "a little."
2 = "about as often as not," "an average amount."
3 = "usually," "a good deal," "frequently."
4 = "regularly," "practically always," "entirely."

A SCORECARD FOR WIVES

1. Do you allow your husband an appropriate amount of the family income, to spend as he chooses, without accounting? 0 1 2 3 4

2. Do you still "court" him with an occasional gift of flowers; by remembrance of birthdays and anniversaries; by unexpected attentions? 0 1 2 3 4

3. Are you cooperative in handling the children, taking your full share of responsibility and also backing him up? 0 1 2 3 4

4. Do you make it a point never to criticize him before others? 0 1 2 3 4

5. Do you share at least half your recreation hours with him? 0 1 2 3 4

6. Do you show interest in and respect for his intellectual life? 0 1 2 3 4

7. Do you show as much consideration and courtesy to his relatives as you do to your own? 0 1 2 3 4

8. Do you enter sympathetically into his plans for social activities, trying to do your full share as a hostess in your own home and, when a guest in the homes of others, trying to make him appear to the best possible advantage? 0 1 2 3 4

9. Do you make an effort to understand the peculiarities of masculine psychology and to help him through his varying moods? 0 1 2 3 4

10. Do you tell him at least once a day that you love him, and act as if you meant it? 0 1 2 3 4

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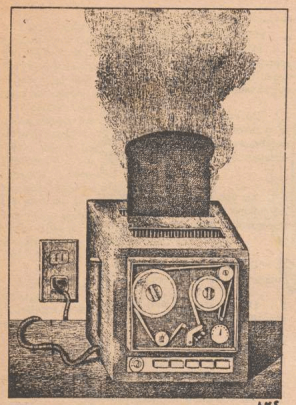
ON PROFESSIONALISM-THE DISCUSSION CONTINUES...



This is a reply to the article on professionalism in RT, *Vol. 2, No. 5 by Nancy Henley and Phil Brown. We encourage more dialogue on this matter.*

The article on The Myth of Skills and the Class Nature of Professionalism by Nancy Henley and Phil Brown, although it made some good radical intellectual points about the class nature of professionalism, potentially creates a dangerous myth that skills are a myth. They are intellectuals creating theory from their own heads rather than from practice. Neither of them has gone through the experience of being trained as therapists. That theory should come from practice is a marxist approach and is and was a distinguishing point between marxism and bourgeoise utopian thinkers who dreamt up theories. My criticism of them comes out of a part my own political practice.

Their article used loaded new left patriotic words like "mystification", "power" and "professionalism", and somehow linked them with the word skill. There is no question that skills can be and are manipulated and used by the ruling class to maintain power positions and class oppression to further fascist designs. When the ruling class doesn't succeed with these subtle things they turn to fascist violence with guns and bombs. We clearly label the use of guns in fascist hands as tools of oppression just as we label guns well used in the hands of revolutionaries as tools of liberation. By the same reasoning, how can we not label skills in the hands of revolutionaries as tools of liberation. But by Phil and Nancy's argument of guilt by association, skills are only tools of oppression, that is if skills exist at all for them.

Skills do exist in my frame of reference. Because of some medical skills I have, movement people used to come to me as a "good untrained person" for psychiatric reasons, and I was able to help some. Since I have been involved in learning and applying psychiatric skills although I may still feel inadequate, I find myself being considerably more useful to people either directly or at least helping them decide whether it is something they can work out themselves or need some help with. I can only say from my own experience of depending on natural ability and now trained ability, that there really is a significant difference in my level of usefulness.

Nancy and Phil say that to "label an ability to deal with human problems as a skill, removing it from the realm of ordinary human accomplishments, is adding to the mystification." We all have abilities; the question is the degree and in what area. A form of mystification occurs when there is an arbitrariness of how those people with certain abilities are chosen to develop them into skills. Can you imagine the NLF selecting sharpshooters randomly because shooting is a human skill and we all should be able to be sharpshooters. We can bet that they select them from those with the best raw abilities and develop their skills. In China, doctors are selected from their communes by voting on who is likely to be the best doctor for the commune. They are then sent to medical school or training to develop their natural abilities into medical *and psychiatric skills*. It is beyond my reasoning to understand why this shouldn't apply to developing of psychiatric skills here (It is a given that the present selection method has a tremendous class, race, and sex bias). This doesn't mean that those who want to develop their skills to a higher level through the process of practice and training creates mystification.

Their statement that "the pernicious suggestion that therapy skills, even radical ones, may be learned and taught pushes the mystification process ever forward." really mystifies me. It not only contradicts the training programs in China, but also my political practice of the last three years of working in collectives which taught a variety of skills to movement people. The only way I can understand Nancy and Phil's position is to say that psychiatric skills are somehow different than other skills we are able to develop like karate, first aid, how to make a leaflet, or organize a demonstration, auto mechanics, etc. To take this position,however, would really be mystifying psychiatric skills. Again, from my own practice I do not find the general process of developing psychiatric skills from raw abilities any different than the process of learning these other skills. Contrary to Nancy and Phil's position, I have found that the teaching and learning of those skills like psychiatric skills will usually demystify them.

Their point about the danger of a new breed of "superheros will arise, movement therapists, a specialization within a specialization..." is quite relevant. Partly because of the ego tripping of *The Radical Therapist* there has developed a mystique of the radical therapist. Another part of this is that this literary mystique plays into the needs of movement people who want to see themselves as special, different from the rest of the population. The more I use my psychiatric skills to serve the people, the more I have come to see movement people are really human beings with human problems like everyone else. There are some difference because one had to understand how human problems interact with the political framework we in the movement are working in. This may seem like an obvious statement, but when you have heard statements of specialness from people that "they (other therapists) can't treat me because

I am a radical" more than just a few times you get scared. It is true that bourgeois,fascist mental health workers often do not understand a left political life style, but beyond that, there are liberal therapists, or new technique therapists (who often call themselves radical for their technique and not their politics) who are quite capable of incorporating a left political frame of reference into the therapy process. If movement people will only allow a politically radical therapist to work with them, they will severely constrict their resources. An example of this is a collective in Detroit which was desperately looking for help from people with psychiatric skills but had discounted all nearby potentially useful people by rejecting liberal therapists with "you can't help us because we are radicals and you don't understand our problems." After much struggle with a member around the myth of their specialness he was able to agree that there might be several liberal therapists who could relate to their human problems in a non-fascist way and who had the potential, with the help of the collective, to understand the political components of their problem.

Ken Cousens

The reason that I feel so strongly that it is a dangerous myth that skills are a myth not only comes out of my personal practice but also the experiences of other movement people. Huey P. Newton said "The spirit of the people is greater than the man's technology". This is a right on statement, but in practice it has sometimes been turned around to mean that because we are revolutionaries our spirit will overcome the man's technology. This not only leads us into the delusion that if we can wish or demonstrate hard enough, the man will hand over his power, hand over his guns, skills, bombs; and also means that we do not need to develop skills to fight our struggle. Anyone who has been in the movement a short time is aware of the shortage of skills, including personal survival or support skills. Hence, Nancy and Phil's myth serves to cover up our vulnerabilities rather than allowing us to identify and work on them. Skills develop out of practice and not wishful thinking.

Perhaps the most tragic illustration of this is the early, unfortunate deaths of two weather people in the New York town house explosion. (From the movement news accounts I am making some assumptions about what happened.) Partly because they were in the early phases of developing their technology, but also because of a righteous revolutionary zeal of their spirit being greater than the technology, safety, and fatigue, they had a tragic accident.

Another example of the danger of the myth of the "no skills myth" is the binds it puts individuals and collectives who feel the collective should be able to solve their or the collectives problems, I have had several real unhappy individuals sneak out of their collective setting to talk with me. They felt even worse because their collectives couldn't really help them. . . . and it was supposed to – the RT said so. It was unfortunate that their pain and difficulty had to get really bad before they could overcome their guilt and let practice overrule theory and seek solutions outside of their collective. Not only do these people suffer, but their collective has to suffer unnecessary failure feelings because they are ruled by their moral "shoulds" rather than their practice. These collectives also tended to develop covert activity around these issues rather than open struggle because of the guilt around the "shoulds". This doesn't negate Nancy and Phil's right on statement that "one of the maddening facts of our time that people believe themselves incapable of dealing with the most ordinary human conflicts without the aid of a specialist". It is very important that collectives and individuals become self-reliant, as the North Koreans say . . . develop Juché. The way to do it, however, is not to ignore the reality of skills, but to develop those skills to avoid the dependency that comes from lack of knowledge and skills. In particular, if we assume that movement people, like other people, sometimes have more than "ordinary human conflicts", it becomes critical we develop at least the skills to make a distinction between the ordinary and that which may require more than just what the collective can give them alone. The point is that untrained people are quite capable of handling ordinary human problems, but contrary to the implied thinking of Nancy and Phil that – because we are human we do not need skills to handle, or even distinguish more than ordinary human or collective problems – there are certain problems or resources that need more than a collective can reasonably offer and we do need additional skills to distinguish and treat these. Like in any other area, first aid karate, automechanics, house building etc., where we are forced to go beyond our daily experience, we need to learn, grow, and develop skills or be forever at the mercy of the oppressors.

It is rather a long response to an article, but I find it harder and harder to suffer mine and the unnecessary failures of people who sincerely allowed their lives to be ruled by the theory and God of *should* of radical intellectuals, rather than the political realities of their own practice. The dialectical process of growth becomes stunted if we allow our practice of *is* to be overwhelmed by our theories of *should*.

To RT Readers in the Twin Cities area:
We understand there are no RT groups in our area but we would like to meet with other readers who might be interested in setting up a discussion group.

Jim Frost and David Wilmes
New Connection
719 Portland Avenue
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Telephone 222-3168

REPLY TO COUSENS

Phil Brown
Nancy Henley

Ken Cousens repeatedly does not understand our argument that "therapy" is not a skill like auto mechanics. We believe that all emotional problems are problems of direct or indirect oppression, problems of living in a crazy place where discussions like this go on. Auto mechanics is a set of *definite* skills which are applied to every car in the same way. This sort of skill is not a human interaction in its application (although it may be in terms of *who* is taught to fix cars). Helping people, however, is not so arbitrary and redundant – it involves calling on your own humanness which cannot be "given" or "acquired."

The claim that we "seem to be creating theory apart from social practice" is not supported by any evidence in Cousens' paper, so it is difficult to counter directly. If it is based on the knowledge that neither of us is a shrink, we deny that this is a disqualification (no one would demand that to criticize capitalist exploitation one must first become a capitalist exploiter). We can only reply that our lives are our practice, and that our position grows out of our lives and experiences.

Experience of your own life, of others lives, and the experience of other truly radical "therapists" is what counts. (And we mean mainly non-professional "therapists.") Those are not things you learn in psychiatry training, psychology training, or any other institution; those are things that we share with one another in terms of sensitivity to suffering, a worldview of the society and its victims, and awareness of what we can do to help.

We trust our gut feelings a lot. We have helped many people get through emotional crises through that trust – trust flows between people when it is real.

We feel there are misinterpretations of a number of our arguments and statements. For example, we would not agree that ". ...skills – if they exist at all – are only tools of oppression", or that ". . .we do not need to develop skills to fight our struggle," or that we encourage people "to be ruled by the theory and god of 'should' rather than by the political realities of their own practice."* Nor do we agree that our arguments can lead to Cousens' conclusions, if understood properly. We especially resent the whole passage that develops Cousens' ideas (not ours) about movement people's misinterpretation of Huey Newton – it smacks of the "lefter-than-thou" game.

It's also "lefter-than-thou" to tell us that the NLF doesn't choose sharpshooters at random. Helping people as a "therapist" is not a matter of pulling a trigger. As for China's selection of people to receive psychiatric training – we must take care not to fall into the trap of uncritical praise of China. We really dig China, and think that the Chinese people are building a beautiful society, but we also have criticisms. China, like Cuba, has gone pretty far, but they are still very reliant on drug "therapy" and traditional theories of emotional problems. What is important about China and Cuba and similar countries is that *the building of the new society is therapeutic* – very few people in those countries suffer emotionally – and that's a function of shared experience in the revolution, not pedantically "taught" skills. It's also important to recall that therapy in China is often largely a matter of political re-education.

Cousens tells us that our obstinacy prevents movement people from going to liberal shrinks. He feels that liberal shrinks can be "quite capable of incorporating a left political frame of reference into the therapy process." Well, we're not talking about "incorporating" a little of this, and a little of that. We're talking about a life-style of comradeship, sharing, and trusting; and that way of living tells us that *no one* can understand your pain and fear unless they share that with you by being part of your movement. We're sick of liberal shrinks who "incorporate" what and when they wish, who talk about Esalen and the sexual revolution and then rape their patients. We're through with liberal shrinks who see our living situations as "transitional" until we accept our correct (liberal) social roles. We're tired of being on the *outside* and of having the *outside* relate to us. We're finished with liberal shrinks raking in tens of thousands a year, and sometimes condescending to do their trip on us. Where do they live? Who does their laundry? What revolution are they involved in?

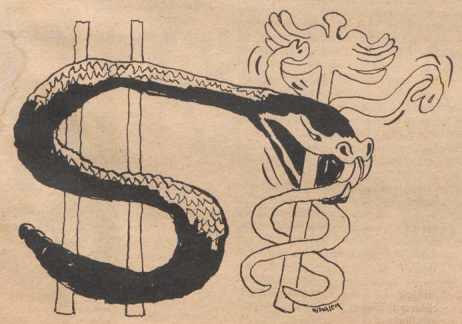
There is, further, a type of movement elitism in the statement, "There are some differences [between 'movement' people and 'other' people] because one has to understand how human problems interact with the political framework we in the movement are working in." The notion that movement people are "human people with human problems," *except* that they have a political framework they're working in, implying that there's nothing political to other people's lives and situations is a dangerous point of view for even a liberal therapist, and well illuminates the problem of expecting a therapist to adapt herself or himself situationally to a particular political framework.

The examples from collectives' experience that Cousens cites to illustrate "the danger of the myth of the 'no skills myth' " are poor arguments at best: they present examples of bad practice, not bad theory.

We should also not be misinterpreted as believing that people do not need to go outside their immediate situations at times for help with their problems, though we would state that there are times when going outside that situation would take the form of reading and applying political thought or of restructuring the situation itself. The problems most likely resulted not from intrapsychic or interpersonal causes, so much as from a lack of political kinship.

It seems that one of the most positive things that psychiatrists could do would be to re-learn their medical skills (those are skills) and provide medical service to working-class free clinics, Panther clinics, and the like. Psychiatrists who consider themselves radical must question the nonsense that the psychiatric authorities have pushed on them. The revolution goes on daily, and we try to live it in new ways, to get into closer communication with people, and to break down the destructive barriers of professionalist oppression. We hope some professionals will join the struggle – there are many battles ahead.

**"Shoulds"* are important, but they don't exclude the realities of practice. Developing "shoulds" means to prefigure what life would be like in a revolutionary society, and to understand the direction we must move in.



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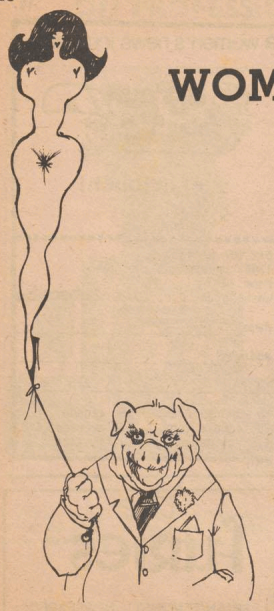


Jessica

WOMAN'S PAIN

Dorothy Riddle

How does one begin to capture the pain of women alienated from their bodies, taught to mistrust their own feelings and instincts, brainwashed into believing that the "other" always knows best? How does one begin to build up a woman's pride in herself and her own intrinsic "rightness," to build up her belief in her own pain and suffering, to build up her self-confidence so that she will never again let that pain be demeaned or negated? Perhaps by women sharing their experiences with each other, showing each other that they too have the same doubts and misgivings, shouting aloud how they finally came to see that *medical oppression must stop*. And so this is my sharing, my trying to recreate my own slow process towards gaining my own integrity.

Where does it start, the knowing-about-yourself only if the doctor tells you it is so? (Though it is not just the doctor – it is everyone bigger and "better" than you, especially men; and so especially men doctors, though women doctors can hurt the most because we forget that they too have been brain-washed by men, and expect them to understand.) Did it start for me back when I "knew" that I was sick but was told that it was only because I hadn't done my homework? Or with the splinter that didn't come out for so many months, though I "knew" it was there and my hand throbbed? Or when I was afraid of a shot and so the polio vaccine got used up before my mother could come and insist that my fear be treated kindly and that I be given a shot? So many small incidents that built up in my head to "no one will believe me"/"Am I really right?" The seeds of the first are easier to see than the seeds of the second. But the seeds of the second are there, all right – just waiting for the first big test. Of course I was always healthy so there would be no problems. And if there were, I could handle them. Like the time the college doctor told me there was nothing wrong, although I was blacking out with painful headache, and I saved my money and went to a private doctor and, sure enough, severe sinus infection – I felt very proud. Other people might not be able to assert themselves and take care of themselves, but I could. I was one in a million.

And then I (the "Glenn Gould of the organ") injured my back, injured it so that I could hardly walk, could not sit or stand comfortably, certainly could not give my junior organ recital. And the doctor (a private doctor, because I had learned my lesson) said there was nothing wrong – it was just because midterm exams were almost there (sound familiar?). And I began to go crazy with fear that there was nothing wrong, but also crazy with fear that there was *something* wrong. And so, paralyzed by my fear, it was a month, a long month of agony, of addiction to codeine, to anything to stop the pain, before I could demand that the doctor examine my back. (How could I have overlooked so simple a procedure, have accepted the doctor's word when he hadn't even examined me? With all my pride in my "rightness," why didn't it occur to me that the doctor could be *wrong*?) Lo and behold, my spinal column was completely out of whack, pinching nerves and making leg muscles waste away!

So once again I was right, right that the pain was real, right that there was something wrong with my back – but the "am I *really* right?" business had caught hold. And the vacillation process continued; through five years of pain and muscle wastage and eight prominent specialists: "yes, wear a brace and do these exercises;" "no, with the brace you will soon be unable to walk, and the exercises are making you worse;" "yes, do surgery and fuse the spine;" "no, then she will be unable to walk for sure;" "yes, you will be permanently crippled;" "no, it is all in your head." It took one and one-half years for me to ignore the doctors, take off the brace, and swallow tons of pain-killers, and begin to get my strength back. It took another three and one-half years before I could scream at a specialist (who had gone over to the "it's all in your head, women often express psychological problems through lower back pain" group, when ten days of tests revealed no clue) that I would not be put off by the consolation that I would probably only have recurrences about once a year and that the only major problem (not being able to drive or to play tennis or to hike or to play the organ were not major) would be that I would be bed-ridden if I elected to bear children.

And, thank god, the pain that had accumulated in those five years was sufficient to embarrass him into trying "one more procedure" which pinpointed the problem – a ludicrously simple, constitutional problem which could have been corrected for in the first month after my accident so that I would have had no further problems, instead of being a semi-cripple for the rest of my life. Now, you may say, she will have learned her lesson, she will never again be intimidated by doctors. I thought so, returning triumphant to pick up the threads of my life – but not conscious of the insidious effect of the specialists asking me, each time I returned for a follow-up, how my therapy was going (I was a clinical psychology graduate student); and certainly unaware that, while he had boasted to everyone on the service after his "success" and had had me examined *ad nauseum* to prove his point, he had never bothered to change his original diagnosis in my chart of "lower back pain of unknown etiology, probably psychiatric in origin" so that this diagnosis would come up again to plague me.

The next four years followed relatively peacefully, with only minor skirmishes about whether or not I had mononucleosis again (I did, though the doctor said it was medically impossible and refused for two months to take a blood test), whether or not cauterizing the cervix would hurt (it did! too much raw, inflammed tissue for it not to), and so on. The one area in which I was being hurt was one about which I was completely unaware and so could not help myself – I had a series of urinary tract infections which were treated by large doses of sulpha (without a routine test being done to find out if the infection was sensitive to sulpha), and so I landed up being allergic to sulpha and with such entrenched inflammation (in the Skene glands) that surgery was necessary.

But I am getting ahead of myself. As I said, there were four years of quiet, when I felt good and strong and sure of myself – not realizing that I could feel sure of myself only because there were no major problems, no reason to doubt my own pain and sanity. And then, abruptly, the lull was over. The vaginal infections I had had from time to time became constant; and doctor after doctor insisted that the fault lay in my refusal to follow directions (though I followed all directions to the letter), rather than in the medicines used. Expensive specialists ignored my protests and prescribed drugs which had never helped (and didn't then). Doctors began hinting at emotional factors, but I remained adamant. The now constant urinary tract infections were explained by a psychiatrist as coming from childhood traumas, so I terminated therapy. Oh, I was very together and sure of myself – it was easy to see that the fault lay with medical malpractice or ignorance.

But then, two years later, came the not-so-simple symptoms. The excruciating menstrual pain, the menstrual irregularity, the abdominal tenderness and cramps and pain, the leg pains, the nausea and dizziness, the pain on sexual arousal. Doctors dismissed most of these symptoms as due to getting older or the flu – or stated flatly that I felt no pain. What do you do when your pain is negated and dismissed, when the most debilitating pain of all (pain on sexual arousal) is "of course psychiatric?" Never mind the fact that blood rushing into inflammed and scarred tissue will produce pain, any symptom related to sexual arousal must be psychiatric. And so the symptoms dragged on and I visited more and more specialists, until finally one day an internist said "this is serious" and a gynecologist said "Why didn't you come in ten months ago when you could have been cured in ten days?" and I was put to bed for four months. You may say that at least I persisted, but who can measure the undermining of self-confidence that takes place appointment after appointment, month after month? One or two reassurances do not restore all that has been worn away, but I did not know that then.

And so for four months I lay on my back, hoping to be cured and "knowing" I was not, wanting to reassure the doctors that I was a "good patient" and so was getting better, feeling whiney and bitchy as I forced myself to say truthfully that I was not quite well. And then the four months were up and I was *not* well, as promised, but any day now...And that waiting went on for four more months while I got weaker and more nauseous, and the pain steadily increased, and the doctors said it was not good and something had to be done. Writing this now, four months seems such a short time, but it was an eternity of ever-increasing pain to live through (and work through, for I had to support myself).

But what was to be done? My doctors had exhausted their skills and knowledge, and so I went to a "famous hospital" to see an "eminent specialist." Surgery seemed indicated, but my vaginal infection could not be controlled by any drug available. The now year-old urethral surgery had not healed, and subsequent treatment had only produced more, painful scar tissue. But the new specialist was "the best" and had an experimental drug to try on my vaginal infection, and so my hopes soared. Of course he would make me well! My troubles were over! So sure was I that this new doctor would want to heal me that I forgot all of my hard-learned lessons about how human and fallible doctors are.

The first two weeks were a mixture of exhilaration and fury – exhilaration because the experimental drug *did* knock out the vaginal fungus; fury because my doctor refused to discuss any aspect of the case with me and flatly denied my pain (while telling me that the condition I had was very painful). In my innocence, I had thought that any and every bit of information about my medical history would help in making a diagnosis, so (a detective at heart) I had set about compiling a detailed, written medical history rather than rely on just what I would remember at the time. And how was this received? Surreptitiously with gratitude by a tired resident who now would not have to write out my history, but publicly by the medical staff as an "unhealthy obsession with my body, indicating severe psychiatric disturbance." What a pathetic attempt to hold on to their superior status and knowledge, but how much it cost me! That, coupled with my desire to discuss openly the indications for and against a hysterectomy (the only long-term cure at present) when I was young, unmarried, and had no children (which automatically ruled out a hysterectomy since I would naturally want children), made the doctor certain that I needed psychiatric help. My protests that my ability to bear children was of secondary importance to me compared with being *well* (especially given my medical history) only made him more certain that I had psychosexual problems and was engaged in a "flight from femininity." So for two weeks I paid to see a psychiatrist to appease my doctor – a psychiatrist who vacillated between feeling that I *did* have psychosexual problems (he finally agreed with the argument that, if they were that severe, they could not be treated in several weeks), and feeling that my doctor was very threatened so that his role (the psychiatrist's) should be that of ombudsperson.

What is amazing to me, given all my previous experience, is that it still took me two weeks (no, seventeen days) to realize that my famous doctor *could not treat me!* What a novel idea to suddenly realize that it was not my problem that I made him uptight, but his problem that he did not have the objectivity to disqualify himself. For that is certainly what he should have done ethically. He was too threatened by a woman who did not fit his conception of femininity, by a woman who was intelligent and had read gynecology texts and recent research articles, by a woman who knew her own medical history and condition and its implications, by a woman who considered herself his professional equal – and the contradictions in his behavior should have made that crystal clear. For he would prescribe medication which had not been helpful in the past (as indicated in my chart); refuse to discuss gynecology with me because it was his specialty, not mine, while indulging repeatedly in psychological inferences and diagnosis (my specialty) without seeing any parallel; alternate between saying that my problem was that I refuse intensive psychotherapy and that my problem was that I refused to take my physical problem seriously and "submit" to the appropriate physical treatment for it.

To this day I do not know if I would have had the guts to confront him without the final precipitating event. For everyone else in my world was telling me to play along with him, humor him, get "less defensive" so that I could "see that he was right." And I needed him because I needed that experimental drug, because he was "the best" and where else could I go? But, fortunately for me, he went too far – he tried to prescribe a course of treatment which I knew would be disastrous given my medical history. What if I hadn't done enough reading to know that...?

from BATTLE ACTS

-- Lynn Shelton

new collage

But I did know, and I refused, and the refusal was easy because I was fighting for my life. And the refusal was hard, very hard. For he threatened to discharge me that very night and make it impossible for me to ever again see a gynecologist at that hospital (which he had the power to do). And reminding him that I needed that experimental drug, which I could get nowhere else, moved him not at all – he relished that power. And so, to gain time, I had to admit tacitly that I had a psychiatric problem and stall for time by asking for a psychiatric consultation the next day. And I had to encourage the myth that it was my fault that we had a "personality conflict." which the psychiatrist played up (and maybe believed). And then finally there was a royal ceremony for a changing of doctors and a changing of doctors' colors – on my chart, my door, my bed, my wristband – and I was free.

Fortunately my new doctor was very good and open (especially about his biases) and so it ended up a good experience. And now I am proud of myself and sure of my own togetherness and convinced that "it will never happen again." But already the new treatment may not be working, and I may have to move on to other doctors, and will I be together with them and so sure of my own pain? I can only hope that I have begun to learn that doctors are not infallible and so, if they care and try, they must be given a fair chance to make mistakes and correct them. But I also hope that I have learned to believe in my own pain and not to be talked out of it and to know that, if I do not take good care of myself, no one else can.

blushing crow of the week

Therapy Is Change Not Adjustment

misbehavior tomorrow .....

The above amazingly original slogan has just been used by an expensive weekly social science newsletter that is quick to rap others on the knuckles on ethical issues. Wonder if RT could try using it?

Revolutionary theory from

RADICAL AMERICA

Vol. V, #5 Documents from the 1969-1970 struggles in Turin and Milan -- Staughton Lynd, A Model Steel Contract -- Work in America: The Postal Employee (96 pp., $1.00)

Vol. V, #6 Marxism Today C.L.R. James: Workers and Peasants, George Jackson, World Revolution -- Paul Buhle: American Marxism and the Period Ahead -- Documents from the Black Workers Congress (96 pp., $1.00)

Subscription: $5/year, or $9/year for joint-subscription with *Socialist Revolution*. 1878 Mass. Ave. Cambridge, Mass 02140 **New Catalog of RA literature, 15¢.**

EDWARD THE DYKE and other poems by Judy Grahn

with drawings by Wendy Gadden, Brenda Crider and Gail Hodgins is available for $1.25 ($1.00 bulk) from: Judy Grahn, 5251 Broadway, Oakland, Ca. 94618.

LETTERS AND

The RT staff discussed these two letters at a regular meeting and felt the points were well taken. Crumb and the Freak Brothers do connote the blatant anti-woman view of the New Left heavies, even though they sometimes satirize it. We prefer original graphics, but they are not always available. In the future we will be more circumspect about obvious and subtle sexism (and racism and middleclass-bias) in our graphics. We're grateful for the two readers' writing us about this.

Dear Radical Therapist,

You know, (I don't know how to put this) . . . Those R. Crumb freak-brothers *et al.* cartoons give me a queasy feeling. They threaten me: they remind me so vividly of that old male left (still going strong, of course) which gave me so much pain before I woke up and got out.

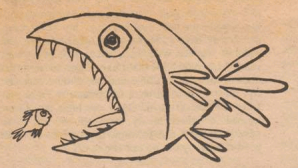
What I'm wondering is this: has anyone written you complaining of the sexism in them? Am I the only one bothered?

Some of it's that terrible subtle kind of sexism –you know, which isn't so much an outright degradation of women as it is a *women-are-invisible* kind of thing. Like showing a crowd of anonymous looking, "sexless," bland everyday people – all of whom on examination, turn out to be male. Cartoonists do it without thinking, I guess. So did the Renaissance artists; all their portrayals of nude children just happened to be male children. (I'm in art history; I become more aware everyday).

This is the most frightening part of sexism, you know. Anybody can spot *women-as-object*. But what about *women-as-irrelevant?*

Have another cartoon.

Jessica Murray
Providence, R.I.



MINNEAPOLIS (LNS) –The Emma Willard Task Force on Education, an independent group of Minneapolis women, has completed a packet of materials relating to sexism in education. It includes articles explaining the problem, proposals for change, classroom materials, and resource lists. The cost of the packet is $3.50 by mail and can be obtained from EWTFE, 1520 W. 27th St., Minneapolis, Minn., 55408.

Dear Radical Therapist:

I have been enthusiastic about the fertile *Radical Therapists* arriving here but for one major criticism. You and your friends are handling many crucial issues sensitively but my expectations, as a Feminist, have not been fulfilled.

Opening up to the Freak Brothers confirms my beliefs that the sexist underground lives on. These boys, funny as some may feel they are, represent a huge block in the Feminist movement. No more, *RT*, can we let anyone say: "But, boys will be boys." (And, I doubt whether *RT* is into sacrificing ideals to reap the consumers' fields.)

In February's issue, page 8, there was again a demonstration (unconscious, probably) of the Male Culture, HuMANity. Why only a penis pissing when half the urine of the world flows out of urethrae? (Artistically, it could be just as amusing.)

I believe in *RT*'s value. I believe you have intended to support Feminism with fine articles and comprehensive news items. But, I also believe that NOW you must rise to the occasion and share in the skyrocketing of consciousnesses.

The illustrations I gave are of the variety causing people to call Feminists "paranoid". But these kind of things go so deep you can't even see the bottom. The Women-Are-Invisible Theory is invisible; its perpetrators are never punished – usually they don't understand. This kind of discrimination is too OBVIOUS to understand. It's too UBIQUITOUS to find.

Am I the only one who has written in about this?

Don't let *RT* develop this kind of venefic veneer.

Elsa King
Toronto, Ontario

Dear Friends:

We are looking for people to join us on a 148 acre farm in Central Pennsylvania. We will be moving to this farm the beginning of April. This is an outgrowth of our present residence where we have had as members of our family (15 of us) a number of adolescents, who for various reasons, were not able to live in the homes of their parents. In most cases, these adolescents have been described by some people as "disruptive."

We are looking for mature patient people who are sensitive to the needs of adolescents and people who have a diversity of skills, farming, construction, music, etc. There is some money available that will provide for subsistence living. We hope to build an alternative to jails and mental hospitals for these adolescents through building a viable community of people working together to become self sufficient. Please contact Nick or Karen Brink: 246 S. Burrowes St., State College, Pennsylvania, 16801. Phone: (814) 237-1918.

Nick Brink
State College, Pa.

The Feminist Press
c/o SUNY College of Old Westbury
Box 334
Old Westbury, New York 11568

announces the release of two children's books entitled:

The Dragon and the Doctor
by Barbara Danish – $1.00.

Challenge to Become a Doctor: The Story of Elizabeth Blackwell
by Leah Lurie Heyn – $1.50.

Three other non-sexist books are available from Lollipop Power, Inc.
P.O. Box 1171
Chapel Hill, North Carolina 27514
Write them for more information on books available.

Workshop on the Rights of Children
P.O. Box 4413
Berkeley, California 94704

is gathering material relating to illegal child-child and adult-child sexual relationships. Particularly needed are personal accounts from both points of view giving an idea of how long it went on and some statement about the overall effect on both partners. We are concerned to confront these age-of-consent laws which make criminals of the children as well as parents or teachers who learn of such activity and do not interfere. We are particularly interested in word from people with experience in religiously supported institutions practicing close confinement of children, where sexual relationships are discouraged and even masturbation is forbidden.

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ANNOUNCEMENTS

Dear RT people

Your essay on the myth of skill and the class nature of professionalism: I don't have it all in hand. I do think it is wrong about the myth of skill thing and right about the class nature of professionalism.

When I read the first paragraph I remembered my grandfather. He earned his living by doing carpentry and cabinet making. One time he set out to help me learn carpentry. My hands were too weak to do straight sawing and nailing so I didn't learn it. I was also too slow with the math and my attention span was short. Anyway I didn't learn carpentry from him. (Don't be sad, I learned some later when I was bigger.) I count what he did as a bunch of skills. He learned them from some guy older than he. You, or I, could say that there was no good skill that being a carpenter conferred on him because all he did was make things with his hands and anyone could do that. On the other hand you can go over to my hometown and find furniture and houses that people have been using for 20 or 30 years. I feel that Grandpa was more skilled than I. He in fact was in the top 50% of carpenters in the whole town of Jamestown, North Dakota.

I think your idea about skill is that there is no such thing because you said so. I don't like that. I do like your idea about people using their skills in support of collectivity. I'd like it if you would write some more about that. I think collectivizing emotional support and help will speed the end of professional rip-offs. Each of us needs to work to put as much skill as there is into every person's head and hands so that we all can have more say in how our lives will go.

If you don't believe what I am saying about skill try it out. Do something that you have never tried before and then compare your results with someone who has been at it for a while.

So long.

Jerry Spinarski
Wausau, Wisconsin

Dear RT:

Hey, wait a minute, Claude Steiner, write your feelings and ideas; don't write a "manifesto." It is because your radical ideas are vitally important, that the inconsistency of your authoritarian style is alienating. You talk about alpha, beta and gamma psychiatrists and trash them all with a brush of the pen – then you talk about – the one and only radical therapy – founded and fostered by Steiner and fans. Thanks, now those of us who feel we are radical therapists can look up our category in your index.

Looks like you've become the kind of rigid spokesman for THE TRUTH whom you so violently oppose. Who gives you the right to make blanket statements that tell others what to do? Aren't you one of the "people"? To be more specific, you make highly valid criticism of individual therapy, then you proceed to dump it, chanting "the group's the thing." Now maybe this is true for you, and if you talked about your personal experience and why you find groups are more meaningful, it would be a more valid statement. I personally find that groups and individual therapy are different and both can be penetrating and intensive change agents. When we do not slip into the traditional therapy games, a close personal relationship can be meaningful in the lives of both the person seeking help and the therapist.

In addition, I find your conception of the initial necessity of a therapist in a group to be unconvincing. How do you explain the fact that some leaderless groups can function so well? It seems to me again, very much a question of the level and goals of the group, and the capacity of the members to relate. What is right for one person or one group may not be right for another. Your way of doing therapy may work well for you, and it is great that you were able to communicate to others what you do. Many of us can benefit from your sharing and your ability to articulate the principles which you describe. What I object to is not basically what you say, but the assumption that you can speak for all, your experience or position – "lefter than thou" – gives you the privilege of writing a manifesto.

The process of change is frightening; openness involves risk. In defense of our uncertainties it is tempting to retreat to the attitude of "I have the answer," but let's face it, life just ain't that simple.

Pat Webbink
Washington, D.C.

We are a group of women interested in writing a pamphlet evaluating how psychological services serve the needs of women in Madison. We feel that psychiatrists and clinicians use two sets of standards in evaluating the mental health of men and women, and that women who go to these clinicians for help are not looked on as individuals, but as women, whose main problem is their inability to adjust to a sex role. We want our pamphlet to help women find therapists who won't serve as society's adjustor.

In compiling our pamphlet we have interviewed representatives from the services. We have come away from these interviews with the feeling that our most important questions were not dealt with. We came out with a lot of liberal generalizations about women and we could not tell if these were really representative of the kind of treatment that women received or even if these were the true feelings of the therapist we talked to.

We would like to know if anyone else has attempted this kind of study. Please write us and tell us if you had similar problems in setting up a basis for decision on which therapists have questioned their traditional views of the role society has established for women, and how you went about solving those problems. We also want to hear from women who have had either good or bad experiences with therapists because we want to include a section on personal experiences. We appreciate any help.

Women's Psychological Study Group
420 W. Wilson
Madison, Wisconsin.

FEMINIST PSYCHOLOGY CONFERENCE

A conference will be held on Saturday, May 6th, from 9:30 a.m. to 5:00 p.m. Workshops will focus on such issues as:

–Can psychology be used to liberate women?
–Can psychologists raise consciousness?
–What is a feminist psychologist?
–What impact has psychology had on female sexuality?

There will be a party for all women attending the conference, starting at 7:30 p.m. Both events, sponsored by the Feminist Psychology Coalition of New York, will be held at the Graduate Center of the City University of New York, 33 West 42nd Street, New York, N.Y. Day care will be provided.

For further details contact:
Judy Greenwald
Room 606, Graduate Center
CUNY, 33 West 42nd Street
New York, N.Y.

RT welcomes the publication of a new journal, *INSANE TIMES*, 1820 Lamont St., NW, Washington, DC, 20010. According to the staff –Nancy Roberts and Bill Roberts– the paper is out on a "trial run" now; hopefully, it will go to monthly publication.

BERKELEY (LNS) – We'd like to introduce LIBERA, a new feminist journal published in Berkeley by and for women. The first issue available this month, contains 56 pages of original material solicited from all over the country – articles, short stories, poetry, film reviews, humor, and numerous graphics. It is professionally typeset and printed on quality 8½ x 11 paper with a glossy, 2-color cover. Rates are $1.25/single copy; $3/3-issue sub. Send away directly to us: Libera, Eshloman Hall, U. of Calif., Berkeley, CA. 94720.

Since we are aiming toward nation-wide distribution, we would appreciate any mention or free advertising you can give us in your publication.

"85" Counseling Center is a non-judgmental phone and walk-in, counselling and referral center. We deal with problems relating to drugs, pregnancy, sex, draft and other hassles. We are a small live-in staff and volunteers. No "pros" except as unpaid consultants.

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Several teachers who are currently fighting to keep their jobs in universities across the country have discussed the possibility of getting together to discuss the nature and extent of political repression in the university today, and ways of collectively combatting it. We are interested in hearing from other students and teachers who are finding it difficult to obtain financial support, find employment, or obtain contract renewals or tenure because of their political activities. If sufficient interest in convening a national Conference on Academic Repression is expressed we hope to have the support of your organization in planning for such a meeting, which would be held in late April or early May.

Contact:
J. David Colfax
Associate Professor
Department of Sociology
Washington University
St. Louis, Missouri 63130

From: Solidarity Films, 2490 Channing Way, Room 207, Berkeley, California, 94704, Tel. (415) 843-7888.

(LNS) We are a group of women with a couple of years' experience in distributing films in the Bay Area and with backgrounds of producing films also.

Recently we have been given a grant to produce a health film. We see this film as dealing with how the medical/drug industry in a profit-motive society oppresses us. Specific groups of people who are oppressed in order for the rich to maintain power and control are Third World people, poor whites and working-class people, kids and the aged, gay people, and people in prison. And within all these areas we especially see women being oppressed and facing very specific problems. We hope the film we are making will show how these people are beginning to take control of their lives by setting up peoples' health alternatives.

We are asking sisters and brothers from all over, who are getting together to combat the big business health industry, who are setting up and working on alternatives, to help us with the film. Send us information you've gotten together, especially anything relating to the groups mentioned above. Send us graphics or visual ideas. Let us know about the communities you serve. This is just the beginning . . . as things become more concrete we'll want people to read over the script to give criticisms and to make any additions. This is your film, a people's film. Together we'll make it, together we will win!

Again, as at the murder of George Jackson, as at the time of the Attica murders, we are hard put to find words to write about our government's ever heavier bombardment of the people of Vietnam and of all Indochina. The words have all been written, the insanity pointed out – and the bombs have been dropped, the lives have been taken, anyway.

Most of us feel helpless: our government has not responded to our protests; the war has not been stopped. But we must learn from the brave Vietnamese people, who refuse to be demoralized and have shown time and time again that they will resist and fight back until their victory is won. Our actions now (not just words), building on past progress in building opposition to the war, are all that will stop the agression.

The ancients used to like to sing about natural beauty:
Snow and flowers, moon and wind, mists, mountains, and rivers.
Today we should make poems including iron and steel,
And the poet also should know how to lead an attack.

–Ho Chi Minh

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